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**‘WOMEN, HEALTH AND HOSPITALS IN BIRMINGHAM’:**

**The Birmingham and Midland Hospital for Women,  
1871 – 1948.**

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**PhD Thesis**

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*For my Father*

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## **Abstract**

This study considers the social history of the Birmingham and Midland Hospitals for Women Incorporated between 1871 and 1948. The hospitals were an integral part of the voluntary hospital system in Birmingham, where two general infirmaries and a range of smaller specialist institutions had been set up to deal with the health care needs of a growing population during the period of industrialization. Two underlying historiographical themes are discussed throughout the thesis; the motivation of those that founded and supported such institutions and the feminist critique of the developments in the practice of gynaecology. Much of the current literature on women's health in this period concentrates on the underlying ideology rather than health care. Here the emphasis is reversed; it is to the medical care and treatment of diseases associated with women's sexual and reproductive organs that this thesis is directed. I have adopted a broadly chronological approach, with Chapters 1 to 4 exploring the founding of the hospital in 1871 and the important early years during which it became established. Chapters 5 to 7 consider developments during the Edwardian period and the inter-war years. In the organization of the individual chapters I have adopted a thematic approach considering the association that different group of people had with the hospital; the governors, medical staff and patients, both within the context of their health care and the lives and circumstances of working-class women in the wider sense. To provide an analytical framework for this study, the dominant historiographical paradigms in the field of women's health are discussed in the introduction to this thesis.

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## Introduction

A registered nurse, I have spent much of my professional life working in the field of women's health. I am aware, therefore, that conditions related to women's sexual and reproductive health continue to cause problems in the twenty-first century. It is reasonable to assume that these were more common in an age of limited understanding of women's physiological make-up, indifferent obstetric care and poor general health. Improvements in the medical care of women were, in part, due to the establishment of hospitals in the latter decades of the nineteenth century, specifically for the treatment of those suffering from 'diseases peculiar to women'. One such institution, the Birmingham and Midland Hospital for Women, is the subject of my thesis. It is my intention to place the history of the hospital in the wider social context; particularly the urban environment and related social problems and to consider how these affected the lives of those women who attended the hospital. I will also consider how religious conviction and political beliefs of the Governors influenced the management of the Institution. Particular attention is given to the role that women played in the Institution, whether as Governors, physicians or surgeons. At the centre of my historical enquiry is the health of women and the care and treatment they received.

My research is based on the archives of the hospital. The detailed minute books of the Management and House Committees help to build a picture of the day-to-day life of the Institution, whilst the Annual Reports describe the objectives of the Institution and discuss the major issues that arose each

year.<sup>1</sup> I have exercised a degree of caution in my reading of the Reports, recognizing that such material was published primarily to inform subscribers and to attract new funding. Nevertheless, I have found that the concerns of Governors are included in the Reports, alongside the more positive achievements. The Reports also reveal the important role that women played within the Institution; it will be shown that men and women worked together as equals in this Charity, many years earlier than perhaps historians have recognized. As with many hospitals, few accounts of patients at the Women's Hospital have survived, although the in-patient registers are complete; these record the age, marital status and occupation of the woman and her husband. Thus, we have an overview of the diseases women suffered from and the treatment they received. The social class of women, judged by the occupation of fathers or husbands, gives an indication of their domestic circumstances, a factor considered by many historians to contribute to ill health. Perhaps of greater interest, are the patient's case notes; these allow for a greater understanding of the patient's experience of ill-health as the medical staff record, in the women's own words, her symptoms. In addition, we have a comprehensive account of medical practice at the hospital; the minutes of the Medical Board and the operating lists include details such as the operative procedures undertaken, the name of the operating surgeon and the outcome. These reports were produced annually, including the mortality rate in each year. There are, however, inevitably limitations in being overly reliant on any one source; thus a variety of contemporary newspapers and

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<sup>1</sup> The Archives are held at Birmingham City Archives, Birmingham Central Library.



periodicals have been used, in addition to an extensive reading of secondary historiography.

The history of medicine has been examined through a number of different theoretical approaches that can be broadly divided into two categories. The older style histories of medicine were often written by medical practitioners, for whom the history of medicine was largely a pursuit in their leisure time. Their studies arose from a deep interest in medicine itself and a desire to learn how medicine had developed through the course of history.<sup>2</sup> One example of this genre, particularly relevant to gynaecology, is J.C. Ricci's classic text *100 Years of Gynaecology, 1800-1900*.<sup>3</sup> Such works have mapped the chronology of the profession's evolution and provide scholars with relevant information regarding historical landmarks in the history of medicine. Whilst these studies are a valuable source of reference, they are too narrowly focused on medical practice and often give little attention to the broader social, economic and political context in which these events took place. Medical history is now largely the province of professional historians, who have broached a range of historical questions that reflect the increasing influence of the social sciences on the discipline.<sup>4</sup> Their historical analyses are weighted towards social and cultural history, dealing with such themes as the treatment of women, the emergence of the medical profession and their exercise of power in the context of decision-making in hospital or asylum.<sup>5</sup>

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<sup>2</sup> L. G. Wilson, 'Medical History without Medicine', *Journal of the History of Medicine*, 35 (1980), pp. 5-7.

<sup>3</sup> J. V. Ricci, *100 Years of Gynaecology, 1800-1900* (Philadelphia, 1945).

<sup>4</sup> There are exceptions to this, for example, the medical historian, Irvine Loudon, *Death in Childbed. An International Study of Maternity Care and Maternal Mortality 1800-1950* (Oxford, 1992), *The Tragedy of Childbed Fever* (Oxford and New York, 2000)

<sup>5</sup> E. Showalter, *The Female Malady. Women, Madness, and English culture, 1830-1980* (paperback edition, London, 1987) (New York, 1985). J. Adams, 'Agency and Influence in the Mixed Economy of Medical Services, Herefordshire c.1770 – c.1800', PhD thesis, University of Warwick, 2004.

Much of this has been critical with regard to some aspects of social policy; particularly concerning the medicalization of maternal health and the health of schoolchildren in the early decades of the twentieth century.<sup>6</sup>

Stephen Cherry has argued that the criticism of the interpretation of the subject by (and primarily for), doctors seems unduly harsh. In turn this has resulted in a distinctly anti-medical history, 'focusing upon the inappropriate nature of medical intervention in, say, mental illness, the treatment of depression or overwork'.<sup>7</sup> The current scholarly emphasis on cultural analysis has led to a more comprehensive understanding of issues, such as the treatment of mental illness or the ideological underpinnings of the medical care of women. The latter subject is particularly relevant in the history of gynaecology but, whilst the speciality now has a wealth of scholarship in a social and cultural context, it is in danger of losing its place within the history of surgery.<sup>8</sup> A notable exception to this is the work of Ornella Moscucci. In *The Science of Women*, Moscucci explores nineteenth-century notions of femininity, men-midwives and the rise of gynaecological surgery in a way that is neither positivistic nor expresses any hostility towards medicine or its practitioners.<sup>9</sup> Similarly, Jane Eliot Sewell has provided a comprehensive analysis of the emergence of gynaecology in the latter decades of the

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<sup>6</sup> S. Cherry, *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge, 1996), p.3. Cherry cites H. Hendrick, 'Child Labour, Medical Capital and the School Medical Service c 1890-1918' in R. Cooter (ed.), *In the Name of the Child. Health and Welfare 1880-1940* (London, 1992), pp.45-71, as an example of this genre.

<sup>7</sup> Ibid., pp.2-3.

<sup>8</sup> J. Eliot Sewell, 'Bountiful Bodies: Spencer Wells, Lawson Tait, and the Birth of British Gynaecology', PhD thesis, John Hopkins University, 1990.

<sup>9</sup> O. Moscucci, *The Science of Women. Gynaecology and Gender in England 1800-1929* (Cambridge, 1990).

nineteenth century in a way that focuses on the medical practice central to her study.<sup>10</sup>

The purpose of this thesis is twofold; to produce a social history of an institution that also records the history of modern gynaecology. It is my intention to offer a broader approach that examines gynaecology with regard to the evolution of medical practice and its relation to the political, economic and social relations within which the practice of medicine was implemented. The aim is to write a history of the Institution that is informed by historiographical theories but based on the archival evidence available. Recent trends in hospital history have been towards closely focused micro-narratives that have revealed the importance of local influences and the role of individuals.<sup>11</sup> I have adopted a similar model in this study. In the main body of analysis, I give a broadly chronological account of the history of the hospital. Chapters One to Four explore the founding of the hospital and the early years until the building of a new hospital in 1905. Chapters Five to Seven examine developments during the Edwardian period and the inter-war years. A thematic style has been used to organize individual chapters, considering the association that different groups of people, such as the Governors and the medical staff, had with the hospital. We also consider the patients, both within the context of their health care and the lives and circumstances of working-class women in the wider sense. The role of middle-class women is discussed and the significant contribution they made to the hospital, as Governors and members of the medical staff.

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<sup>10</sup> Sewell, 'Bountiful Bodies'.

<sup>11</sup> J. McCalman, *Sex and Suffering. Women's Health and a Women's Hospital: The Royal Melbourne Hospital 1856-1996* (Melbourne, 1998), A. Borsay, *Medicine and Charity in Georgian Bath: A Social History of the General Infirmary c. 1739-1830* (Aldershot, 1999).



Two underlying historiographical paradigms are discussed throughout this thesis; the first is the motivation of those founding and supporting such institutions. A recurring theme is the concept of social control which has proved persuasive to many historians.<sup>12</sup> This is a feature of the new discipline of medical sociology that emerged at the end of the 1950s. In its approach the discipline is more orientated towards the patient's perspective, but the underlying analysis reveals the tension between the critical intellectual parentage of sociology and the more utilitarian purpose of medicine. The basis of their argument is founded in Foucault's notions of power and surveillance. Jewson has linked this to the advent of 'Hospital Medicine' and the increasing reliance on 'Laboratory Medicine' whereby the relationship between the patient and the doctor shifted from the patronage of traditional bedside medicine to the subservient nature of a patient reliant on the doctor's knowledge.<sup>13</sup> Others have interpreted philanthropic activities as a self-interested activity in which there may have been an expectation that support would bring social or political advantage.<sup>14</sup> More recently, historians have questioned the notion of philanthropy as a mechanism of power and regard

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<sup>12</sup> J. Seed, 'Theologies of Power: Unitarianism and the Social Relations of Religious Discourse, 1800-1850', in R. J. Morris (ed.), *Class, Power and Social Structure in British Nineteenth-Century Towns* (Leicester, 1986).

<sup>13</sup> N. Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870', *Sociology*, 10 (1976), pp. 225-44.

<sup>14</sup> J.V.Pickstone and S.V.F.Butler, 'The Politics of Medicine in Manchester, 1788-1792: Hospital Reform and Public Health Services in the Early Industrial City', *Medical History*, 28 (1984), A.Wilson, 'The Politics of Medical Improvement in Early Hanoverian London', in A. Cunningham and R. French (eds), *The Medical Enlightenment of the Eighteenth Century* (Cambridge, 1990), R. Porter, 'The Gift Relation: Philanthropy and Provincial Hospital in Eighteenth-Century England', in L. Granshaw and R. Porter (eds), *The Hospital in History* (London, 1992), J. Adams, 'Conflicting Interests: The Campaign for a Public Asylum in Hereford 1836-1839', in J. Reinartz (ed.), *Medicine and Society in the Midlands 1750-1950* (Birmingham, 2007).

such activities as synonymous with humanitarian, practical benevolence.<sup>15</sup>

This argument has informed my approach to this study.

The feminist critique of the putative medicalization of women's health is the dominant paradigm in the historiography of the developments in the practice of gynaecology, which took place in the latter decades of the nineteenth century. The nexus of the feminist argument is that the medical science that underpinned the diagnosis of gynaecological disease owed rather more to the social and cultural attitudes of the period than to medical knowledge.<sup>16</sup> A familiar theme is the victimization of women. Ann Douglas Wood's essay, 'The Fashionable Diseases', is characteristic of this genre.<sup>17</sup> Wood's judgement of male medical practitioners suggests that they were misogynistic or even sadistic. Thus, 'the cauterizer, with his injections, leeches and hot irons, seems suggestive of a veiled but aggressively hostile male sexuality and superiority'. Yet, those practitioners opposed to cauterization, such as S. Weir Mitchell, are accused of carrying the spirit of such treatments to a sophisticated combination. Even the best-intentioned doctor was 'in part hostile to his women patients simply by the misconceptions he was trained to hold'.<sup>18</sup> By this, Wood is referring to the misguided advice given to women to sleep with their spouse 'squarely in the middle of her menstrual cycle'.<sup>19</sup> However, Wood dismisses any suggestion that this was due to the physician's

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<sup>15</sup> F. Prochaska, *Schools of Citizenship: Charity and Civic Virtue* (London, 2002), B. Harrison, *Peaceable Kingdom. Stability and Change in Modern Britain* (Oxford, 1982).

<sup>16</sup> E. Showalter has put forward a similar argument regarding the diagnosis and treatment of mental illness, *The Female Malady*. I have discussed the feminist critique more fully in J. Lockhart, 'Truly, a Hospital for Women: The Birmingham and Midland Hospital for Women 1871-1901', MA dissertation, University of Warwick, 2002.

<sup>17</sup> A. Douglas Wood, 'The Fashionable Diseases: Women's Complaints and Their Treatment in Nineteenth-Century America', in J. W. Leavitt (ed.), *Women and Health in America: Historical Readings* (Wisconsin, 1984), pp.222-38.

<sup>18</sup> *Ibid.*, p.226.

<sup>19</sup> *Ibid.*

ignorance of women's internal organs. Rather, it was an example of the 'psychological warfare (that) was being waged between doctors and their patients'.<sup>20</sup>

Such a position suggests a united and coherent view within the medical profession with regard to gynaecological treatments; this is not supported by the arguments, medical and lay, about developments in the speciality that were frequently the subject of heated debates in the medical press. An example of this is the well-known controversy over a surgical procedure that, whilst not widely practised, illustrates the concerns around female sexuality at this time.<sup>21</sup> Masturbation was a cause of increasing anxiety in nineteenth-century Britain and America; according to Isaac Baker Brown, the habit was linked to a number of female 'disorders', including epilepsy, insanity and hysteria.<sup>22</sup> He based this theory on the work of the neurologist Brown-Sequard concerning general nerve stimulation and suggested that masturbation was caused by peripheral excitement of the pudic nerve (which provides nervous stimulus to the clitoris). On this premise, the logical solution was surgical removal of the clitoris.<sup>23</sup> Baker Brown's work attracted a good deal of attention, sometimes from surprising quarters. His book on *The Curability of certain forms of Insanity, Epilepsy, Catalepsy and Hysteria in Females* was enthusiastically reviewed in the *Church Times*.<sup>24</sup> In the article, it was claimed that Baker Brown 'discovered and applied with great success, a

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<sup>20</sup> Ibid.

<sup>21</sup> A. Dally, *Women under the Knife: A History of Surgery* (London, 1991), pp.162ff

<sup>22</sup> *British Medical Journal*, January, 1866. Cited *ibid.*, p.164.

<sup>23</sup> Ibid.

<sup>24</sup> I. Baker Brown, *The Curability of certain forms of Insanity, Epilepsy, Catalepsy and Hysteria in Females* (London, 1866).



remedy for certain forms of epilepsy and kindred diseases'.<sup>25</sup> Baker Brown had his supporters within the medical profession but many doctors were more cautious and throughout the following months Baker Brown faced a mounting tide of criticism.<sup>26</sup> On 23 June 1866, the *Lancet* published a letter from Dr Gage Moore, who insisted that 'we have scarcely more right to remove a woman's clitoris than we have to deprive a man of his penis'.<sup>27</sup> The attacks gathered momentum when it was reported in *The Times* that Baker Brown was treating women of unsound mind in the London Surgical Home.<sup>28</sup> Similarly, on 19 January 1867 the *British Medical Journal* expressed their concern 'if serious operations had been performed upon patients without their knowledge and consent'.<sup>29</sup> Baker Brown's downfall was swift; following an investigation by the Lunacy Commissioners, The Council of the Obstetrical Society launched an enquiry into the validity of clitoridectomy as a scientific and justifiable operation. Baker Brown was expelled from the society on 3 April 1867, on the grounds of unprofessional behaviour.<sup>30</sup> Thereafter, clitoridectomy was discredited in England (although it continued to be practised in America).

As Regina Markell Morantz-Sanchez has argued, medical practice can only be viewed within the context of scientific ignorance at this time concerning the physiology of reproduction. Morantz-Sanchez also refutes Wood's portrayal of the medical profession as self-serving and sadistic; suggesting that to equate Victorian culture with male antagonism is overly simplistic. She

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<sup>25</sup> *Church Times*, 29 April 1866. Cited *ibid.*, pp.168-69.

<sup>26</sup> For a comprehensive account of the differing opinions within the profession, see *ibid.*, pp.168-80.

<sup>27</sup> *Lancet*, 23 June 1866.

<sup>28</sup> *The Times*, 15 December 1866. Cited *Dally*, p.174.

<sup>29</sup> *British Medical Journal*, 19 January 1867. Cited *ibid.*

<sup>30</sup> *Ibid.*, pp.178-79.

argues that such a position fails to take account of the immense complexities around changes in the family structure in the nineteenth century and the altered attitudes towards sex roles.<sup>31</sup> Morantz-Sanchez was an early critic of the 'victimization' strand of the feminist literature and recent trends in the scholarship in this field reflect a more nuanced approach to historicizing gynaecology. In addition to the work of Moscucci mentioned above, perhaps the most significant are the published works by authors such as Jacalyn Duffin, Ann Dally and Anne Digby.<sup>32</sup> Duffin provides an informed survey of the history of medicine with reference to recent scholarly literature and current issues in health care. Dally attempts to put the contemporary gynaecological treatments into context by analysing it in line with other forms of abdominal surgery, such as appendicectomy. Whilst acknowledging that some gynaecological procedures were of doubtful value, or even unnecessary, Dally has argued that in the longer term, the therapeutic advantages were significant, pointing out that all major surgery is based on the experience gained in ovarian surgery during this period.<sup>33</sup> Furthermore, the archives of this hospital, and contemporary surveys, have revealed a significant amount of chronic ill health among women, frequently the result of too frequent pregnancies or the mismanagement of obstetric care.<sup>34</sup> Pelvic infection was also common and, particularly in the twentieth century, carcinoma of the cervix and ovarian cancer were among the largest causes of death amongst

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<sup>31</sup> R. Markell Morantz, 'The Perils of Feminist History', in Leavitt, *Women and Health in America*, pp.239-45.

<sup>32</sup> J. Duffin, *History of Medicine. A Scandalously Short Introduction* (Toronto, 1999), Dally, *Women Under the Knife*. Moscucci, *The Science of Women*. A. Digby, *Making a Medical Living. Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge, 1994).

<sup>33</sup> Dally, *Women under the Knife*, p.135.

<sup>34</sup> M. Spring Rice, *Working-Class Wives. Their Health and Conditions* (1939) (2nd ed., London, 1989).

women.<sup>35</sup> How the hospital responded to the proven need for medical care is examined throughout this thesis.

Chapter One examines the foundation of the hospital, within the context of the political and social climate of late Victorian Birmingham. An overview is given of Birmingham in the latter decades of the nineteenth century, during which the town witnessed a period of rapid migration, associated with the process of industrialization. As with many industrialized towns, this period of unprecedented growth put tremendous pressure on poorly developed essential services such as housing, sanitation and drainage which subsequently led to deterioration in the health and living conditions of the working classes. The catalyst for change has been seen by historians as the Civic Gospel, as preached by the nonconformist minister George Dawson. For Dawson and those who shared his beliefs, there was no distinction between religion and politics and they called upon their congregations to take a greater interest in civic affairs. This message resonated with the nonconformist community in Birmingham, which included many of the leading industrialists and businessmen in the town. Collectively these families gave generously of their time and their personal wealth in bringing about a civic renewal that included libraries, parks and open spaces and art galleries, as well as essential services such as schools and hospitals.<sup>36</sup> In the context of this thesis, the contribution made by the Chamberlain, Nettlefold, Kenrick and Cadbury families are the most important. As noted above, a number of

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<sup>35</sup> H. Mathers and T. Macintosh, *Born in Sheffield. A History of Women's Health Services 1864-2000* (Barnsley, 2000), E. Shorter, *Women's Bodies: A Social History of Women's Encounter with Health, Ill Health and Medicine* (New Brunswick and London, 1991), especially pp.276-81. E. Thompson, 'Women in Medicine in Late Nineteenth and Early Twentieth Century Edinburgh: A Case Study', PhD thesis, University of Edinburgh, 1998.

<sup>36</sup> A. Briggs, *Victorian Cities* (London, 1968), V. Skipp, *The Making of Victorian Birmingham* (Birmingham, 1983), C. Upton, *A History of Birmingham* (Guildford, 1993).



historians have argued that the concept of reciprocity may have motivated subscribers, whilst others have found the concept of social control persuasive.<sup>37</sup> These well-established paradigms are discussed in this chapter, as is the more recent interpretation of philanthropy as synonymous with the humanitarian, practical benevolence that has been associated with the earlier religious institutions for the sick poor.<sup>38</sup> It will be argued that there is evidence to suggest that similar values guided those who were instrumental in establishing the Birmingham and Midland Hospital for Women.

In Chapter Two the opportunities the hospital provided for middle-class Victorian women to follow a career in medicine and associated health care professions are considered. A summary of the battle for women to enter medicine in the latter decades of the nineteenth century forms the background to the employment of women doctors at the hospital. The Institution was the first to appoint a woman doctor as House Surgeon and thereafter actively sought to employ women in this role; they were also the first to appoint a female consultant. Similarly, the hospital pioneered the employment of female dispensers in Birmingham, a practice they continued until the end of our period in 1948. As Governors, women also played an important part in the management of the Institution. By the latter decades of the nineteenth century this was not unusual, particularly in charities for women and children; however, most charities were managed exclusively by either men or women.<sup>39</sup>

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<sup>37</sup> J.V.Pickstone, *Medicine and Industrial Society. A History of Hospital Development in Manchester and Its Region, 1752-1946* (Manchester, 1985), H. Marland, *Medicine and Society in Wakefield and Huddersfield, 1780-1870* (Cambridge, 1987), Borsay, *Medicine and Charity in Georgian Bath*, Adams, 'Agency and Influence in the Mixed Economy for Medical Services'.

<sup>38</sup> C. Jones, 'Charity Before c1850', in W.F.Bynum and R. Porter (eds), *The Companion Encyclopaedia of the History of Medicine*, Volume 2 (London, 1993), F. K. Prochaska, 'Philanthropy', in F.M.L. Thompson (ed.), *The Cambridge Social History of Britain 1750-1950*, Volume 3 (Cambridge, 1990).

<sup>39</sup> F.K. Prochaska, *Women and Philanthropy in 19th-Century England* (New York, 1980), pp.31-32.

From the outset, women were represented on the Management Board in equal proportion to men and it will be shown that they made a significant contribution to the Institution. Alice Beale for example, who was a Governor for 60 years, was largely responsible for the introduction of convalescent care and the re-opening of the Lying-in Hospital in 1908. The hospital was thought to be the first in the Midlands to appoint a woman President, the Countess of Dudley, in 1893 and, aside from the years that Arthur Chamberlain (co-founder of the hospital) held his post, women were chosen to be President of the Institution. With their greater understanding of the distress that can be caused by gynaecological complaints and as mothers and wives themselves, women had a genuine and proactive interest in issues related to pregnancy and childbirth.

Chapter Three explores the rise of surgical gynaecology in the latter decades of the nineteenth century. The emphasis is on the surgery undertaken at the hospital and the clinical practice of Lawson Tait. Tait, regarded by Arthur Chamberlain as co-founder of the hospital, was a controversial figure whose arrogance and lack of regard for the medical establishment attracted heated criticism from his contemporaries. In part, this reflected the challenge that Tait posed for the older generation of gynaecologists. Aided by developments in scientific medicine, Tait and his contemporaries extended surgical techniques pioneered in the 1860s by surgeons such as Spencer Wells, who regarded these developments in gynaecological practice as a retrograde step. Correspondence in the medical journals suggests that Tait's personality generated much of the heat in the debate; unlike many of his peers, Tait did not have the advantage of a



privileged background and lacked the finesse acquired with this. Traditionally the profession was slow to accept change and to have change promoted by an 'outsider' was even more difficult to accept.<sup>40</sup> Nevertheless, even Tait's detractors acknowledged his outstanding clinical ability and it is unlikely that a man with a more compliant nature would have been able to make such a contribution to the field of gynaecology and general surgery. These issues are explored within the context of the debate amongst contemporary observers regarding developments in gynaecological practice. As noted above, this subject continues to attract interest from historians who have argued that the medical treatment of women in the late nineteenth and early twentieth centuries was informed by the ideology of the period and the social construction of health and disease.<sup>41</sup> It will be argued that the medical care of women and developments in medical science must be considered within the context of the significant degree of ill health, which was largely inappropriately managed at that time.

The patients and their care is discussed in Chapter Four. The archival evidence provides us with information on the number of women admitted to the hospital and the diseases they suffered from. Use is also made of contemporary evidence, such as a study published by the Women's Co-operative Guild which provides us with an insight into the lives of working-class women. As noted above, there are difficulties associated with historical records and these issues are examined within the context of this chapter. We also consider the nursing staff, especially the matron who played a prominent

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<sup>40</sup> See M. J. Peterson, *The Medical Profession in Mid-Victorian London* (Berkley and Los Angeles, California and London, 1978), regarding 'gentlemen practitioners' and the nepotism which influenced hospital appointments.

<sup>41</sup> Nicolas Jewson has argued that all knowledge, including medical knowledge is socially constructed. Jewson, *The Disappearance of the Sick-Man*.

role in hospital life. Of particular interest is the changing nature of nursing, following the Nurse's Registration Act 1919. This is explored against the background of World War I and the subsequent concerns of nurses that the profession was being diluted by the increasing use of barely trained VADs.

Chapter Five commences with the opening of a new hospital in 1905 (considered by contemporaries to be a landmark in the history of the hospital), and continues to the years of the Second World War. The purpose of the chapter is to examine how the governing body met the challenges of the inter-war years; particular attention is given to how they adapted to changes in the funding of voluntary hospitals, whilst facing the increasing pressure of the rising cost of medicine and the use of technology. A second theme of this chapter is the developments in clinical medicine, with emphasis on the introduction of controversial surgery in the treatment of ovarian cancer. As with the early history of gynaecology, feminist historians have been critical of such treatments, suggesting that women received greater care and consideration from practitioners of their own sex.<sup>42</sup> As mentioned above, women doctors were an integral part of the medical staff at the hospital and it will be shown that gender did not influence their medical practice.

The initiatives the Institution took in the wider field of women's health are discussed in Chapter Six. The first of these was the introduction of convalescent care, first introduced in the 1880s, but significantly increased in the early decades of the twentieth century by the opening of a new convalescent home, in conjunction with the new hospital and a second convalescent home in the country. It will be shown that this pattern reflected

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<sup>42</sup> O. Moscucci, 'The "Ineffable Freemasonry of Sex": Feminist Surgeons and the Establishment of Radiotherapy in Early Twentieth-Century Britain', *Bulletin of the History of Medicine*, 81 (2007), pp. 139-63.

developments in convalescent care nationally. The two Homes served a different purpose; Park Road Convalescent Home was adjacent to the hospital and able to offer medical care if necessary. The Gertrude Myer's Convalescent Home, gifted to the hospital by Leopold Myers, essentially offered rest and general care. A second theme explored in this chapter is care of the dying; cancer of the cervix was the major cause of death among women in the latter decades of the nineteenth and first half of the twentieth centuries and many of the patients admitted to the hospital were found to be inoperable. In 1910 the decision was made to open a Home of Rest in association with the Institution; the purpose being to allow women to be cared for in their last days in a peaceful environment, with nursing care and adequate pain relief. As such, the Home anticipated the principles of the hospice movement which has become so well established today.

The final chapter, Chapter Seven, examines the merger in 1911 of the Lying-in Charity and Maternity Hospital with the Women's Hospital. Maternity care and infant welfare was a matter of national concern in the early years of the twentieth century. Governments introduced a number of measures to address these concerns, one of the most important being the registration of midwives in 1902. There is a wealth of scholarship on this subject; feminist historians have pointed out that historically childbirth was the exclusive domain of women. In Britain, male professionals did not attend births until the early eighteenth century; childbirth and the lying-in period were a kind of ritual in which expectant mothers turned to relatives and a few trusted friends to support them during one of the most critical moments in their lives. Central to this group was the midwife who had generally received no formal training and

acquired her knowledge through having borne children herself and possibly through having worked with more experienced midwives before setting up in practice.<sup>43</sup> The 1902 Act undermined the role of the traditional 'handy-woman', and Ann Oakley has argued that subsequent developments in obstetric practice resulted in the medicalization of childbirth, which in turn was a strategy adopted by the state for the social control of women.<sup>44</sup> In this chapter it will be argued that these developments should be considered within the context of the social circumstances of working-class women at that time. There is contemporary evidence that women welcomed admission to hospital for the birth of their children; this makes sense, in light of their hard household labour and the number of young siblings who were likely to be present throughout the confinement. For these reasons, working-class organizations, such as the Women's Co-operative Guild, campaigned for municipal hospitals. As will be demonstrated, at Birmingham Maternity Hospital the emphasis was on domiciliary care and a large district maternity department was developed. These developments are considered within the context of the theoretical debate but largely through the practical implications for patient care.

The object of this thesis is to present an historical account of how the Governors, medical practitioners, hospital staff and a multitude of subscribers responded to the health needs of possibly the majority of Birmingham women, namely, those above the rank of pauper but not wealthy enough to pay for private medical treatment. Well established paradigms regarding the motivation of those founding and supporting such institutions will be examined

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<sup>43</sup> Moscucci, *The Science of Women*, p.43.

<sup>44</sup> A. Oakley, *The Captured Womb. A History of the Medical Care of Pregnant Women* (Oxford and New York, 1984). Oakley bases her argument on Michel Foucault thesis on Power and Knowledge and argues that ante-natal care represented an attempt by the State to control the behaviour of women. This argument is discussed at length in Chapter 11.



and it will be argued that the Victorian notion of philanthropy, that was still evident in the inter-war years, was guided by a number of more humanitarian motives, including religious conviction and benevolence. In the analysis, it will be shown that a considerable number of women did indeed suffer from 'maladies peculiar to their sex'.<sup>45</sup> Thus, that the notion that the health needs of women can be adequately explained by the social construction of health and disease will be questioned. It is proposed that improvements in the health of women during the late nineteenth and early decades of the twentieth centuries and through the inter-war years were in part due to the establishment of voluntary hospitals and the efforts of those who worked within them.

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<sup>45</sup> Birmingham City Archives, The Birmingham and Midland Hospital for Women, HC/WH 1/2/1, Management Committee, 7 March 1871.

## Chapter 1

### *The Founding of a Hospital:*

#### *Philanthropy in Late Victorian Birmingham*

The care of the sick poor has long been embodied in the Christian psyche. Colin Jones has proposed that such practical expressions of faith were guided by Christ's injunction to care for the sick, the needy and the dying and that it was these values that provided a 'charitable template for successive generations'.<sup>1</sup> Religious and political beliefs played an important role in the huge expansion of voluntary hospitals during the eighteenth and nineteenth centuries.<sup>2</sup> This phenomenon has attracted a good deal of scholarly interest. A recurring theme in the historiography is the motivations of those funding and supporting such institutions. The literature in this field is dominated by two opposing interpretations of such motives. The concept of social control has proved persuasive to many historians; others have rejected the notion of philanthropy as a mechanism of power and regard philanthropy as synonymous with a humanitarian, practical benevolence.<sup>3</sup>

Jones has pointed to the deficiencies within the established paradigms, observing that there is a tendency in such strongly bi-polarized accounts to minimize divisions within the social elite. There is also a tendency to exclude

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<sup>1</sup> C. Jones, 'Charity Before c1850', in W. F. Bynum and R. Porter (eds), *The Companion Encyclopaedia of the History of Medicine*, Volume 2 (London, 1993), p.1470.

<sup>2</sup> See R. Porter, 'The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth-Century England', in L. Granshaw and R. Porter (eds), *The Hospital in History* (London, 1989), L. Granshaw, 'The Rise of the Modern Hospital in Britain', in A. Wear (ed.), *Medicine in Society. Historical Essays* (Cambridge, 1992).

<sup>3</sup> For a fuller discussion on the recent historiography see, A. J. Kidd, 'Philanthropy and the Social History Paradigm', *Social History*, 21 (1996), pp.180-92, and C. Jones, 'Some Recent Trends in the History of Charity', in M. Daunton (ed.), *Charity, Self-interest and Welfare in the English Past* (Oxford, 1996).

the working classes, as donors to, as well as or recipients of, charitable relief.<sup>4</sup> Recent trends in the scholarship away from 'grand narratives' towards more closely focused micro narratives will further inform the debate.<sup>5</sup> An historical account of the basis on which a hospital was established and developed provides the historian with an opportunity to investigate the motivations of a range of individuals, Governors, donors and medical practitioners. The aim of this chapter is to consider the founding of the Birmingham and Midland Hospital for Women (hereafter, the Women's Hospital), within the framework of the competing paradigms.<sup>6</sup> Particular attention will be paid to individuals who played a significant role in the founding and early years of the hospital. The role that women played in its management and how this may have influenced the way in which the Charity conducted its affairs, will also be considered. It will be shown that a diversity of cultural, social and economic circumstances shaped the way the hospital progressed. To understand the significance of such factors, it is first necessary to place the hospital within the context of the social, economic and political environment of Victorian Birmingham.

The process of industrialization started early in Birmingham. With the metal trade firmly established in the locality by the beginning of the eighteenth century, the town was well placed to take advantage of the opportunities

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<sup>4</sup> Jones, 'Some Recent Trends in the History of Charity', pp. 51, 57.

<sup>5</sup> Ibid., p.56.

<sup>6</sup> J.V. Pickstone, *Medicine and Industrial Society. A History of Hospital Development in Manchester and its Region, 1752-1946* (Manchester, 1985), H. Marland, *Medicine and Society in Wakefield and Huddersfield, 1780-1870* (Cambridge, 1987), S. Cavallo, 'The Motivations of Benefactors: An Overview of Approaches to the Study of Charity', in J. Barry and C. Jones (eds), *Medicine and Charity Before the Welfare State* (London and New York, 1991), pp. 46-62, A. Borsay, *Medicine and Charity in Georgian Bath: A Social History of the General Infirmary, c.1739-1830* (Aldershot, 1999), J. Adams, 'Agency and Influence in the Mixed Economy for Medical Services. Herefordshire c.1770 - c.1800', PhD thesis, University of Warwick, 2004.

offered by the development of the canal system from the 1770s.<sup>7</sup> By the later decades of the eighteenth century, the export of brass and copper goods, and the growing trade in armaments and 'toys', had earned Birmingham the title of 'the toyshop of Europe', a description first used by the parliamentarian, Edmund Burke, in the 1770s.<sup>8</sup> Some indication of the inward migration resulting from this industrial activity may be obtained from Dr John Ash's reply to opponents to his scheme for a General Hospital in 1765. 'More than half the Manufacturers in the Town of Birmingham are not Parishioners of it, and cannot be entitled to any Relief from the present Infirmary: Many of them are Foreigners, but the greatest Part belong to the Parishes of the neighbouring County'.<sup>9</sup> Immigrants came from much further afield than the surrounding countryside; Chris Upton has shown that, by 1800, a Jewish community, mainly of Eastern European origin, was well established.<sup>10</sup> Birmingham's record of religious tolerance had long attracted people of nonconformist beliefs and many of these immigrants became prominent in industry and commerce. John Taylor and Samuel Lloyd, for example, both Quakers, became two of the town's leading manufacturers and established the first joint-stock bank in Birmingham, the forerunner of Lloyds Bank.<sup>11</sup>

Notwithstanding this industrial and commercial expansion, Birmingham was not a 'factory town'; apart from a handful of larger factories, such as the Soho Works of Matthew Boulton, few manufacturers employed more than 500

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<sup>7</sup> P. Mathias, *The First Industrial Nation. The Economic History of Britain 1700-1914* (2nd ed. London, 1983), pp.101-02.

<sup>8</sup> J. Zuckerman and G. Eley, *Birmingham Heritage* (London, 1979), p.40. 'Toys', meaning in this context hardware such as fire shovels, pokers and tongs. 'Toy's became a comprehensive term for any useful lightweight manufactured article and later included cheap jewellery.

<sup>9</sup> Cited C. Upton, *A History of Birmingham* (Guildford, 1993), p.40.

<sup>10</sup> *Ibid.*, p.100.

<sup>11</sup> Zuckerman and Eley, *Birmingham Heritage*, p.44.



people.<sup>12</sup> Rather, there was a great diversity of occupations; a contemporary commentator noted that there were 'about 520 distinctly classified manufacturers, traders or dealers and about twenty separate professions in Birmingham', which, when further divided, gave about '2,600 varieties of occupation'.<sup>13</sup> Moreover, domestic industry and small-scale workshop production dominated until the latter half of the nineteenth century; the 1871 official factory returns list 4,873 establishments, with an average of only 19 employees per firm.<sup>14</sup> Thus, industrialization was a more gradual process in Birmingham than in some towns in the industrial North of England and thereby its impact less extreme. Nevertheless, as was the experience in other industrial towns and cities, a period of rapid population growth in the early decades of the nineteenth century caused major problems. At the time of the first census in 1801, the population was around 70,000. This number had doubled to 146,986 by 1831 and risen threefold to 232,638 by 1851.<sup>15</sup> To keep pace with the housing needs of this population an energetic programme of building was undertaken and within thirty years the number of dwellings in Birmingham had doubled.<sup>16</sup> The quality of housing varied; terraces of artisans' cottages afforded superior accommodation. A greater number were inferior working-class courtyards of back-to-back houses with a shared privy,

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<sup>12</sup> Ibid., p.44.

<sup>13</sup> Cited J.T. Bunce, *History of the Corporation of Birmingham*, Vol. I (Birmingham, 1878), p.306

<sup>14</sup> V. Skipp, *The Making of Victorian Birmingham* (Birmingham, 1983), p.65.

<sup>15</sup> Birmingham Central Library (hereafter BCL), Local Studies, Annual Abstract of Statistics, No 1, 1931-1949, Table 3.

<sup>16</sup> Ibid., Table 70. Between 1811 and 1841 the number of dwellings in Birmingham town rose from 13,652 to 27,272. There were similar patterns of growth in the neighbouring townships of Derident, Bordesley, Duddeston-cum-Nechells and Edgbaston Parish.

ash-pit and water pump.<sup>17</sup> Nonetheless, contemporary reports stress that working-class housing in Birmingham compared favourably to most other industrial towns, commending the practice of 'each family living in a separate dwelling' as 'conducive to comfort and cleanliness'.<sup>18</sup> Similarly, Edwin Chadwick noted, 'The houses ... are on the whole built to an approved plan ... and the general health of the population is high'.<sup>19</sup>

There was some justification for this statement; a favourable topography, and a near immunity from cholera, had given Birmingham a reputation for being 'one of the healthiest large towns in the kingdom'.<sup>20</sup> Notwithstanding this generally benign environment, by the period 1851-1860, the death rate had risen to 26.51 per 1,000, per annum in Birmingham Parish, far higher than the rates for nearby rural parishes such as King's Norton, where it was 17 per 1,000.<sup>21</sup> According to Dr Thomas Heslop, 'noxious gases' were an important cause of premature death in those, such as brass workers and gilders, who inhaled them in the course of their work.<sup>22</sup> Of greater concern was the mortality rate of children under the age of five years, which, in the most deprived areas of the town, stood at 9.448 per 1,000, some 40 per cent

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<sup>17</sup> Skipp, *Victorian Birmingham*, pp.76-77. Earlier claims that industrialization led to a boom in 'jerry-built' housing have recently been reprinted. In the third edition of his standard text, Derek Fraser acknowledges that, as early nineteenth-century housing is demolished, there was evidence that many of these homes were substantially built and, in terms of materials used, superior to many rural dwellings. D. Fraser, *The Evolution of the British Welfare State* (3rd ed.) (Basingstoke, 2003), pp.62-63.

<sup>18</sup> *The Select Committee on the Health of the Towns 1844*. Cited A. Briggs, *Victorian Cities* (London, 1968), p.187.

<sup>19</sup> *Sanitary Conditions of the Labouring Poor, Poor Law Commissioners. Edwin Chadwick Report* (London, 1842), HL.-XXVII.

<sup>20</sup> T.P.Heslop, 'The Medical Aspects of Birmingham', in S. Timmins, *Birmingham and the Midland Hardware District* (Birmingham 1866) (reprinted, Birmingham 1967) p. 689.

<sup>21</sup> Over the same period the national average was 22.24 per 1,000. Supplement to the Twenty-Fifth Annual Report of the Registrar-General of Births, Deaths and Marriages, 1864. Cited *ibid.*, p.693.

<sup>22</sup> *Ibid.*, pp. 698-99.

above the national average.<sup>23</sup> The same pattern could be seen in other large towns, where the high general mortality rate could mainly be accounted for by the number of deaths amongst children.<sup>24</sup> Contemporaries attributed this to the increasing proportion of married women who worked in factories, leaving their child reliant on artificial food and in the care of siblings, themselves of tender years.<sup>25</sup> There is evidence to suggest that women were attracted to the employment offered in the new lighter industries that were being established in the town. The steel pen factory of Joseph Gillot, for example, was dominated by female labour.<sup>26</sup> However, Birmingham women, or children seldom undertook the heavy labour required in the mines or brickyards, and conditions were generally less oppressive than those in the large textile mills of the North.<sup>27</sup> Indeed, the *Children's Employment Commission* of 1843 stressed the 'general good usage of children in Birmingham'.<sup>28</sup>

Notwithstanding contemporary concerns about the employment of young mothers, it is probable that the cause of the high rate of death among infants and young children was much the same as in other large towns and cities. Endemic diseases, such as typhus, tuberculosis, measles and scarlet fever were the main killers, whilst diarrhoea and dysentery were 'remarkably prevalent' and diphtheria had 'displayed itself in full vigour' from 1856 onwards.<sup>29</sup> As elsewhere, these were the disastrous consequences of the rise of industrial towns and cities and the concomitant deterioration of public

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<sup>23</sup> Ibid., p.694.

<sup>24</sup> In districts with a low general mortality rate of 17.53 per 1,000, 5.29 per cent of deaths were those of children under five years of age. Heslop, *The Medical Aspects of Birmingham*, p.694.

<sup>25</sup> Skipp, *Victorian Birmingham*, p.67.

<sup>26</sup> Upton, *A History of Birmingham*, p.176.

<sup>27</sup> For a fuller discussion on the work of women and children, see I. Pinchbeck, *Women Workers and the Industrial Revolution, 1750-1850* (London, 1969).

<sup>28</sup> Cited Skipp, *Victorian Birmingham*, p.67.

<sup>29</sup> Heslop, *Birmingham and the Midlands Hardware District*, p.689.



hygiene. Some progress had been made in the early decades of the century; for example, Birmingham was the first town in England to introduce piped water.<sup>30</sup> Conversely, the town also had 20,000 middens and, by the late 1840s, much of the water supply was polluted.<sup>31</sup> Edwin Chadwick's *Report on the Sanitary Conditions of the Labouring Population of Great Britain*, published in 1842, had exposed similar problems elsewhere and he was quite clear where the remedy lay. 'The primary and most important measures ... are drainage, the removal of all refuse of habitations, streets and roads, and the improvement of the supplies of water.'<sup>32</sup>

Chadwick's *Report* exposed the public health problem, but it was to be the (1848) Public Health Act, which provided the stimulus for action. Although generally ineffective, in as much as it was permissive legislation, the Act contained provision for the establishment of local Boards of Health. Birmingham Corporation immediately ordered a survey of housing and sanitary conditions in the town, as a precursor to establishing a Local Board of Health. Robert Rawlinson's subsequent report (1849) focused on the drainage and sewage disposal within the Borough. The conditions in the 2,000 courts in the town centre attracted the harshest criticism. Very few had water closets and Rawlinson noted that 'The common practice is that the manure is mixed with ashes and rubbish ... till it over-runs the seats, runs into the courts, and gives rise to noxious exhalations'.<sup>33</sup> As Mr Richard Cadbury, a witness to the enquiry testified, those living in the middle-class areas of the

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<sup>30</sup> Skipp, *Victorian Birmingham*, pp. 90-93.

<sup>31</sup> C. Gill and C.G. Robertson, *A Short History of Birmingham from its Origin to the Present Day* (Birmingham, 1938), p.55.

<sup>32</sup> *Sanitary Conditions of the Labouring Poor Law Commissioners. Edwin Chadwick Report* (London, 1842), HL -XXVII.

town fared little better. Here the gutters were 'receptacles of drains and filth till they become in a most putrid state, reeking with the contents of water-closets in the finest neighbourhood in Birmingham'.<sup>34</sup> Despite Rawlinson's indictment, much the same conditions still existed when Dr Hill, the Medical Officer for Health, conducted a further enquiry in 1875. Diseases, such as diarrhoea, scarlatina, fever, measles, smallpox, whooping-cough and diphtheria were still common; consequently, there had been little improvement in the infant mortality rate. In the overcrowded courts, the death rate was 26.82 per 1,000, twice the level of that in the middle-class areas, such as Edgbaston.<sup>35</sup>

In part, this was due to political squabbles over who should have power locally. The town had received its Charter of Incorporation in 1838. However, the Charter did not abolish other organs of local administration. There followed eleven years of controversy as the Corporation battled to extend its powers and secure control of all essential services within the parliamentary borough of Birmingham.<sup>36</sup> Given the support for liberal policies nationally by many members of the newly reconstituted council, it is perhaps surprising that their early years in office were marked by a series of missed opportunities. For example, several proposals to appoint a Medical Officer of Health were defeated, until a clause in the 1872 Public Health Act made such an appointment compulsory.<sup>37</sup> Essentially, strict economy underpinned council policy in the early years, and it would appear that this strategy had popular

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<sup>33</sup> R. Rawlinson, 'Report into the Sanitary Conditions of the Borough of Birmingham'. Cited Bunce, *History of the Corporation of Birmingham*, p.323.

<sup>34</sup> *Ibid.*, p.327.

<sup>35</sup> Cited Upton, *A History of Birmingham*, p.136.

<sup>36</sup> Gill and Robertson, *A Short History of Birmingham*, pp. 46-47.

<sup>37</sup> *Ibid.*

support. A proposal by more enlightened members to increase the Council's borrowing powers through a new Improvement Bill in 1855 was soundly rejected at a public meeting of ratepayers.<sup>38</sup> However, whilst the Town Council were refusing to spend money, a more radical message about the nature and role of local government was being preached elsewhere.

For George Dawson, the nonconformist minister most closely associated with the ethos of the civic gospel, there was no distinction between religion and politics. Speaking eloquently from his pulpit each Sunday, he called upon his congregation to take a greater interest in civic affairs. Dawson's congregation included many of Birmingham's most influential families and he urged them to give all their talents to the city 'to secure the services on the Town Council of men who were not only able, but gifted with something above ordinary talent and wisdom'.<sup>39</sup> Dawson was the pioneer of the civic gospel but other nonconformist ministers, such as H.W. Crosskey at the Unitarian Church of the Messiah and Charles Vince of Graham Street Chapel, were to take forward his 'gospel of public duty'. Perhaps the most influential was Dr R.W. Dale, minister of Carr's Lane Congregational Church. Following Dawson, Dale believed in a wider role for civic authorities and argued that they already had the power to 'greatly diminish the amount of sickness in the community, they can do much to improve those miserable homes which are fatal not only to health, but to decency and morality'.<sup>40</sup> Like Dawson, Dale looked to businessmen to bring about a civic renaissance, urging them to become aldermen and councillors and 'to give their time as well as their money to whatever improvements are intended to develop the intelligence of

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<sup>38</sup> Briggs, *Victorian Cities*, p.211.

the community'.<sup>41</sup> In Joseph Chamberlain and others who shared his convictions, Dale found exactly the sort of person he had been seeking.

It was during the mayoralty of Joseph Chamberlain (1873-1876) that the first concerted attempts were made to address public health issues. To paraphrase Chamberlain's words, the town was 'parked, paved, assized, marketed, gas-and-watered and *improved*' within the space of three years.<sup>42</sup> The municipal vitality that characterized the Chamberlain era has been well documented and space does not permit it to be discussed further here.<sup>43</sup> Of greater importance, in the context of this thesis, is the contribution his brother, Arthur Chamberlain, made to the socio-economic life of the town. Like Joseph, Arthur Chamberlain was an ardent Radical and a prominent member of the Birmingham Liberal Club. However, he did not pursue a political career and directed his attention to the family's business interests. Thus, essentially, Chamberlain was industrialist and his most recent biographer concentrates on Chamberlain's commercial interests and highly successful business career.<sup>44</sup> In contrast, the obituaries published at the time of his death gave a more rounded account of his life. Chamberlain's service to the community, as a member of the Town Council and an active member of King's Norton School Board was noted, as was his support of the University of Birmingham and his interest in the Training School for Nurses. Like his brother, Arthur Chamberlain was a member of the Unitarian Church of the Messiah and took

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<sup>39</sup> Cited Skipp, *Victorian Birmingham*, pp. 155-56.

<sup>40</sup> Cited Briggs, *Victorian Cities*, p.201.

<sup>41</sup> *Ibid.*, p.201.

<sup>42</sup> Cited *ibid.*, p.231.

<sup>43</sup> See Briggs, *Victorian Cities*, Skipp, *Victorian Birmingham*, Upton, *A History of Birmingham*.

<sup>44</sup> B.M.D. Smith, 'Chamberlain, Arthur (1842-1913)', *Oxford Dictionary of National Biography* (Oxford, 2004, accessed 31 October 2004: <http://www.oxforddnb.article> 46812).



a great interest in its various agencies.<sup>45</sup> However, in his tribute to Chamberlain, the Lord Mayor suggested that there were two things in his public life of particular note; one was his work on the licensing bench, the other was the 'founding of the Women's Hospital', which would be 'a lasting tribute to him'.<sup>46</sup>

This accolade was well founded; although medical staff had been canvassing support for a hospital for women in Birmingham, little had been achieved before Chamberlain took an active interest in the project. The need for such an institution had arisen following the closure of the Lying-in Hospital, amidst a growing concern at the evidence that women who were delivered in hospital died in greater numbers than women delivered in their own homes. The cause of the high mortality rate was infection, notably puerperal fever, a disease that spread rapidly through a ward of post-partum women.<sup>47</sup> This led many within the medical profession to conclude that lying-in hospitals were undesirable. Thereby, in 1867, a decision was made to close the hospital and move exclusively to a domicillary system of maternity care.<sup>48</sup> The wisdom of this action was confirmed by the favourable statistics presented at the Annual Meeting of the Lying-in Charity in 1871. In the preceding year, only two deaths of mothers had occurred within the ten-day post-partum period, both of

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<sup>45</sup> This summary has been compiled from the biographical sketch published in the *Birmingham Post*, 22 October 1913.

<sup>46</sup> Ibid.

<sup>47</sup> Statistical evidence comparing the mortality of mothers delivered in lying-in hospitals to those delivered in their own homes demonstrated that, across Europe, both maternal and infant mortality was invariably greater in hospital. D. Phelan, 'Report on the comparative advantages of attending women in Lying-in Hospitals, and in their own homes', *Dublin Quarterly Journal of Medical Science*, February 1867. Cited *Birmingham Post*, 13 June 1867.

<sup>48</sup> The reasons for the closure were complex. In the year before its closure the hospital had a debt of £1,200, largely due to its costs, which were higher than other specialist hospitals in the town. The underlying problem was the low bed occupancy. See, J. Lockhart, 'Truly, a Hospital for Women: The Birmingham and Midland Hospital for Women 1871-1901', MA dissertation, University of Warwick, 2002.



whom had a history of chronic ill health before admission.<sup>49</sup> Nonetheless, there remained the problem of gynaecological patients. Although intended primarily for maternity patients, the Lying-in Hospital had also treated the ordinary diseases of women and children. Moreover, the proportion of such patients had been growing year on year; in 1842, gynaecological cases represented 39.5 per cent of all admissions, by 1867 this had risen to 53 per cent.<sup>50</sup> Such figures suggested that some provision for women with gynaecological disorders still needed to be made.

The surgeon, Ross Jordan, was the first to propose that the building no longer required for midwifery patients be retained as a hospital devoted entirely to 'the diseases peculiar to women'.<sup>51</sup> Jordan could have been reasonably confident of success. The growth of specialist hospitals was one of the most significant features of medical practice in the nineteenth century.<sup>52</sup> In Europe and America, teaching and research were centred around such hospitals, allowing international links to be established between clinicians who had developed a special interests. There were also a number of independent influences that fostered the move towards specialization, notably the growth of towns and cities which provided the large populations needed to support specialist practice.<sup>53</sup> A number of specialist hospitals in Birmingham had been

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<sup>49</sup> *Birmingham Post*, 24 November 1871. For a wider analyses of the issues facing Lying-in hospitals see C. Stephenson, 'The Voluntary Maternity Hospital: A Social History of Provincial Institutions with Special Reference to Maternal Mortality, 1860-1930', PhD thesis, University of Warwick, 1993.

<sup>50</sup> Birmingham City Archives (hereafter BCA), Archives of The Lying-in Hospital, HC/MH 1/1/1, summary of the 25th Annual Report, November 1867.

<sup>51</sup> BCA, Archives of The Birmingham and Midland Hospital for Women (hereafter BMHW), HC/WH 1/10/1, Annual Report, March 1872, Appendix 1.

<sup>52</sup> I have discussed this further in J. Lockhart, 'Truly, a Hospital for Women: The Birmingham and Midland Hospital for Women, 1871-1901', in J. Reinartz (ed.), *Medicine and Society in the Midlands 1750-1950* (Birmingham, 2007), pp. 81-97.

<sup>53</sup> R. Stevens, *Medical Practice in Modern England. The Impact of Specialisation and State Medicine* (New Haven and London, 1966), pp 26-27. See also, G. Rosen, *The Structure of*

set up by medical practitioners, including the Orthopaedic Hospital (1817), an Eye Hospital (1823), and the Ear and Throat Infirmary (1844).<sup>54</sup> Elsewhere, gynaecologists were establishing hospitals for their speciality. Protheroe Smith had founded the first Hospital for the Disease of Women in 1843 and more recently, Dr Aveling and Dr Jackson had co-founded the Sheffield Hospital for Women, in 1864.<sup>55</sup> Lindsay Granshaw has argued that new hospitals were relatively easy for medical practitioners to establish. A doctor need only rent a small house where a few patients could be cared for, supervised by a 'matron', and he could be sure of attracting sufficient patients. The long-term success of an institution, however, depended on whether the practitioner could attract sufficient charitable support.<sup>56</sup> Herein lay the difficulty, whilst Jordan had the support of the other medical staff associated with the Lying-in Charity, less enthusiasm was forthcoming from the governors and subscribers. It was estimated that a sum of some £1,000 would be required to re-open the hospital and the governors doubted that they would be able to raise this amount of money.<sup>57</sup> It was evident that the success of the venture was dependent upon obtaining the sponsorship of an influential and trusted member of the local community. Such a person would be able to enlist the support of potential subscribers and raise the necessary capital to start afresh.

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*American Medical Practice 1875-1941* (Pennsylvania, 1983), G. Weisz, *Divide and Conquer. A Comparative History of Medical Specialisation* (Oxford and New York, 2006).

<sup>54</sup> J. Reinartz, 'Healthcare and the Second City: the Development of the Teaching Hospitals in the Nineteenth Century', *Birmingham Historian*, 26 (2004), pp.16,19, 21.

<sup>55</sup> H. Mathers and T. McIntosh, *Born in Sheffield: A History of Women's Health Services 1864-2000* (Barnsley, 2000), p.25.

<sup>56</sup> L. Granshaw, 'The Rise of the Modern Hospital in Britain', p.207.

<sup>57</sup> *Daily Gazette*, 13 May 1868.

It is not known how Arthur Chamberlain became aware of the unsuccessful attempt to establish a hospital for women, but howsoever it occurred, he thought that the subject demanded further inquiry. With the same attention to detail that he employed in his business pursuits, Chamberlain researched his subject carefully. Some six months later he had satisfied himself that there was a great need for such an institution in Birmingham and set to work to cost such an undertaking and ascertain that he had friends who would assist him.<sup>58</sup> Having established these facts, Chamberlain called a public meeting on 7 March 1871, to consider a proposal 'that a Hospital, for the diseases peculiar to Women, should at once be established in Birmingham'.<sup>59</sup> Chamberlain spoke first of the professional need for medical specialization, noting that medical science had advanced so rapidly in the last twenty-five years that it had 'rendered the general mastery of the whole subject by one man impossible'.<sup>60</sup> Chamberlain saw the logic in the development of well-defined medical specialities, as he observed, such division of labour was long established in manufacturing. Moreover, he considered it the duty of medical charities to support and participate in changes in medical practice, for it was the 'object of their supporters to combine the best school for training practitioners with the greatest amount of success in combating disease'.<sup>61</sup> Hence, the progression from general infirmaries and dispensaries to specialized institutions, such as eye infirmaries, sanatoria, children's hospitals, and hospitals for women. As Chamberlain pointed out, Birmingham had everything but the latter, yet there was 'no department of medicine where

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<sup>58</sup> BCA, BMHW, HC/WH 1/10/1, Annual Report, March 1872

<sup>59</sup> Ibid., HC/WH 1/1/1, Board of Governors, May 1871.

<sup>60</sup> Ibid., HC/WH 1/10/1, Annual Report, March 1872, Appendix 1,

<sup>61</sup> Ibid.



specialism is more successful in its results than in the treatment of women's diseases'.<sup>62</sup>

Such an institution was thus evidently needed for medical knowledge, but could it be shown that the town needed a hospital specifically for women? He had considered this question in some detail, researching gynaecological care across Britain. Because of its similarity in social conditions, and the occupations of its inhabitants, Chamberlain chose Glasgow as the most suitable for a comparative study. The proportion of cases 'peculiar to women' in the hospitals of both cities was 'singularly close'. In Glasgow Royal Infirmary they represented one case in 60.5 in-patient cases, in Birmingham they represented one case in 65.4 at the General Hospital and one case in 57.4 at the Queen's Hospital; in all institutions the ratio of in-patient to out-patient attendances was the same.<sup>63</sup> However, in Glasgow there were, in addition, two separate institutions, dedicated to diseases of women, which together treated a further 2,000 cases per annum. That brought the ratio of cases to one case in twenty, against the one case in every sixty currently being treated in Birmingham. Thus, in Birmingham, 'for every one patient suffering from these diseases who is treated in hospital, two are unrelieved'.<sup>64</sup>

As to the question of whether the general medical charities should be urged to take them, this could be answered in one way by the number of towns where specialist institutions were now either flourishing or being proposed. Chamberlain cited, 'London, Edinburgh, Dublin, Glasgow, Manchester, Leeds, Liverpool, Sheffield, Bristol, Weymouth etc' as examples of places that offered relief to the working women of their towns, 'without

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<sup>62</sup> Ibid.



interfering with the work of other medical charities'.<sup>65</sup> Moreover, men of the highest professional standing, including 'the late Sir James Simpson, Mr Spencer Wells, Dr Keith and Dr Prothero Smith' gave 'weighty and most grave' reasons why patients did better in small specialist institutions. This was most evident in one particular disease that often required 'the most formidable undertaking in surgery'.<sup>66</sup> Statistics for the leading hospitals in London, and their own general hospitals, showed that no less than 62 in 100 such cases died. By way of comparasion, Dr Keith, in his 'little hospital' in Edinburgh had achieved remarkable results, eighty-one of the one hundred patients he had operated on had recovered. In other words, patients suffering from this disease had a 'thrice better chance of her life in a small separate institution than in a large general hospital'.<sup>67</sup> Furthermore, the benefits did not only accrue to working women. As Chamberlain pointed out, the lack of expertise locally meant that women in the wealthier classes were obliged to seek treatment in London, a situation that was as inconvenient to the patient as it was unsatisfactory to the profession. The opportunity should be given to local practitioners, who were just as skilful, to improve their knowledge and thereby their treatment of special female diseases.<sup>68</sup>

Chamberlain concluded his speech with a direct appeal for sympathy, tempered with Unitarian utility. 'Many poor gentlewomen supporting themselves' and others who were 'above the position of the generality of the labouring poor' who, when attacked by such maladies, 'were unwilling to beg

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<sup>63</sup> Ibid.

<sup>64</sup> Ibid.

<sup>65</sup> Ibid.

<sup>66</sup> Ibid. The name of the disease is not given but it probable that the procedure referred to was ovariectomy, later described as oophorectomy.

<sup>67</sup> Ibid.

for admission to a general hospital', yet too poor to afford the expense of treatment in their homes. Thus, they lingered until they were incapacitated and 'the poorhouse or the grave ends their career'.<sup>69</sup> The proposal put before them would provide some relief to such patients, many of whom 'could be restored to health and the power to earn a living'.<sup>70</sup> It is recorded that the motion was passed 'by a resolution of one of the largest public meetings that for any similar purpose has been held in Birmingham for many years'.<sup>71</sup> Thereby, Chamberlain had achieved in six months what others had been working towards for more than two years. A colleague attributed his success to the effort Chamberlain had put into making himself acquainted with the subject, so that 'when he came before the public meeting his case was thoroughly made out'.<sup>72</sup> There is no record of the arguments that Jordan and his colleagues put forward in support of their cause, but Chamberlain's approach differed significantly to that adopted by medical men involved in a similar campaign.

Ornella Moscucci has shown that Protheroe Smith's arguments for founding a hospital for women rested on two theories. Firstly, Smith's claim that women's complaints were accompanied by much suffering and 'nervous sensibility' which required 'specially trained attendants and a quiet and restful environment to avoid the dangers of nervous excitement'.<sup>73</sup> This argument resonates with the theories of women's sexual and reproductive health, discussed in the introduction to this thesis, theories that still had currency in

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<sup>68</sup> Ibid.

<sup>69</sup> Ibid.

<sup>70</sup> Ibid.

<sup>71</sup> Ibid., HC/WH 1/10/1, Annual Report, March 1872.

<sup>72</sup> Ibid.

the 1870s.<sup>74</sup> Smith's second line of argument posited the theory that gynaecological disorders among the poor were the consequence of the insanitary conditions of their environment. The damp overcrowded living conditions in the slums, and hours spent in the impure atmosphere of ill-ventilated workshops, all contributed to the uterine diseases common among such women. Thereby, reliance on domiciliary treatment in such circumstances was unlikely to be efficacious; the solution was to place the patient in an environment where proper care, and a clean and orderly environment, would aid recovery.<sup>75</sup> Moscucci has interpreted Smith's argument for orderliness and sanitation as 'a plea for a form of moral and bodily discipline which locked poor women into a socially subordinate position'.<sup>76</sup> In contrast, Chamberlain's case reflected his Unitarian philosophy. If Chamberlain shared some of Smith's intellectual concerns about the living conditions of working women, the provision of such an institution was seen in the wider context of social responsibility, preached by Dawson and others, described above.

Chamberlain had clearly anticipated that the motion would be carried and was able to announce the next steps. A provisional committee would be established to draw up the rules of the Charity, obtain donations and subscriptions and secure a building, then report on progress to a general meeting of subscribers. Some six weeks later, all this had been achieved. The financial support required for the initial development had been promised;

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<sup>73</sup> O. Moscucci, *The Science of Women. Gynaecology and Gender in England 1800-1929* (Cambridge, 1990), p.82.

<sup>74</sup> See, for example, Dr Henry Maudsley, 'Sex and Mind in Education', *Fortnightly Review*, 21 (1874), pp. 466-83.

<sup>75</sup> Moscucci, *The Science of Women*, pp. 82-83.

<sup>76</sup> *Ibid.*, p. 85.

the lease on a house purchased and sufficient subscriptions and donations received to commence operations.<sup>77</sup> Of critical importance was the support of the friends and colleagues that Chamberlain gathered around him. The names of families associated with the hospital throughout much of our period, such as Kenrick, Gladstone, Beale, Lloyd, Sturge and Cadbury, were central to the business, social and intellectual life of Birmingham. These families provided whole dynasties of civic leaders and, the frequency with which the same names appear in association with charitable organizations, suggests that public duty in its widest sense had become an established tradition amongst the leading nonconformist families.<sup>78</sup>

The commitment to social responsibility was evident in women no less than men. As early as 1825, an alliance of Quaker women, like Mary Samuel Lloyd, Maria Cadbury and Sophia Sturge, founded the Birmingham Female Society for the Relief of Negro Slaves.<sup>79</sup> By 1885, there were 'ladies on the School Board, lady Guardians, lady doctors, a special Women's property Protection Act, &c., &c.'<sup>80</sup> As Showell observed in his *Dictionary of Birmingham*, it could hardly be said that 'ladies were much curtailed of their liberty'.<sup>81</sup> Showell attributed all this activity to the strength of the Woman's Rights movement in Birmingham. A local branch of the Women's Suffrage Association had been formed in 1868, followed by a Women's Liberal Association (1873), a branch of the National Union of Working Women (1875),

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<sup>77</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, May 1871.

<sup>78</sup> Skipp, *Victorian Birmingham*, p.119.

<sup>79</sup> Upton, *History of Birmingham*, p.34.

<sup>80</sup> T. Harman (ed.), *Showell's Dictionary of Birmingham* (1885) (Republished, Wakefield, 1969), p.336.

<sup>81</sup> *Ibid.*



and a Woman Ratepayers' Protection Society, established in 1881.<sup>82</sup> A prominent member of the Women's Right's movement was Eliza Sturge, niece of Sophia and Joseph Sturge, anti-slavery campaigner and Reform activist. Following her uncle, Eliza was deeply committed to the suffrage movement and actively involved in the Birmingham branch of the Women's Suffrage Association. In particular, Sturge emphasised 'the right of women to work, side by side with men for the public good'.<sup>83</sup> She argued that class, not gender determined the treatment women received and was especially concerned that the social and educational system restricted the spiritual and intellectual development of working-class women.<sup>84</sup> Thus, Eliza took a keen interest in education and was the first woman to be elected to the Birmingham School Board, joining Chamberlain and Dixon in their landslide victory for the Liberal/nonconformist candidates in 1873.<sup>85</sup> Having established a precedent, Eliza stood down in 1876, to concentrate on her interests in the suffrage movement and temperance reform.<sup>86</sup> Eliza's career was entirely compatible with nonconformist traditions of liberal dissent and progressive views towards womanhood. The realities of domestic life, however, precluded many women from realizing the expectation of personal fulfilment engendered by their more advanced education.<sup>87</sup> It was the frustration caused by such limitations, often unwittingly imposed, which drew many Unitarian women towards feminism.<sup>88</sup>

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<sup>82</sup> Ibid.

<sup>83</sup> E. Sturge, *Englishwoman's Review*, 38 (1906), pp. 122-23.

<sup>84</sup> K.D. Reynolds, 'Sturge, Eliza Mary (1842-1905)', in *Oxford Dictionary of National Biography* (accessed 31 October 2004: <http://www.oxforddnb.com/article/56273>).

<sup>85</sup> Harman, *Showell's Dictionary of Birmingham*, p.276.

<sup>86</sup> Reynolds, 'Sturge, Eliza Mary'.

<sup>87</sup> K. Gleadle, *The Early Feminists. Radical Unitarians and the Emergence of the Women's Rights Movement, 1831-51* (London, 1995), pp. 26-27.

<sup>88</sup> Ibid., pp. 27-29.

A greater number found fulfilment in philanthropic work, which allowed them to discharge their Unitarian obligation of public duty, whilst providing the intellectual stimulus they craved.<sup>89</sup> Margaret Green has shown how, from the 1860s, the middle-class women of Birmingham, notably from nonconformist families, involved themselves in numerous causes to improve the lives of women and children. Mary Showell Rogers, for example, was founder of the Ladies Association for the Care of Friendless Girls, which aimed to save young women from crime and prostitution, whilst Julia Lloyd was closely involved in the Birmingham Nursery School Movement. Alice Beale, whose family was involved in the founding of the Nurses' Training Institute, was active in a number of women's organizations, including the Birmingham Settlement for Women and Children.<sup>90</sup> An enduring critique of such activities is that they were an attempt to demonstrate the benign use of middle-class wealth and thereby served to improve the relations between the social elite and the working population.<sup>91</sup> Whilst acknowledging that amongst the ruling classes there was an expectation of deference in return for their philanthropic efforts, Frank Prochaska rejects the 'murky and reductionist' social control theories posited by historians such as F.M.L. Thompson and Gareth Steadman Jones.<sup>92</sup> Undoubtedly, it was hoped that the influence of respectable women would encourage healthy and moral ideas among women and young girls from the deprived inner city areas of Birmingham. Nonetheless, it is easy to overplay attempts to inculcate middle-class cultural

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<sup>89</sup> Ibid., p.30.

<sup>90</sup> M.D. Green, *Images of England. Birmingham Woman* (Stroud, 2000), pp. 7-8, 52-55.

<sup>91</sup> G. Steadman Jones, 'Class Expression versus Social Control?', *History Workshop*, 4 (1977), pp. 163-70, F.M.L. Thompson, 'Social Control in Victorian Britain', *Economic History Review*, 2nd series, 34 (1981), pp. 189-208.

values among the working classes. As Prochaska has noted, paternalistic interference required some co-operation from the recipients, who must have perceived some benefit from the philanthropic efforts of the well-to-do.<sup>93</sup> The support given to many charitable institutions in Birmingham, particularly those concerned with education or medical care, suggests that they were broadly welcomed by the working population.<sup>94</sup>

The families of the aforementioned women were all closely connected with the Women's Hospital and provided substantial financial support. In addition to their annual subscriptions, the Chamberlain family and their circle of friends made regular substantial donations.<sup>95</sup> Another generous benefactor was Louisa Anne Ryland, who offered one of her own buildings, rent-free to the hospital to accommodate a new in-patient department and donated a further £500 towards upgrading the property.<sup>96</sup> As with other medical charities, however, regular subscriptions were the most important source of income and provided some measure of financial stability.<sup>97</sup> Annual subscriptions, 10/6d for a lady, 21/- for gentlemen, or £10 guineas for life, were a requirement to qualify as a governor.<sup>98</sup> These represented around 72 per cent of the charitable income throughout the 1880s.<sup>99</sup> Subscriptions and donations came from all sections of society. Showell observed that the contributions on Hospital Sundays came 'almost solely from the middle and more wealthy

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<sup>92</sup> F. K. Prochaska, 'Philanthropy', in F.M.L. Thompson (ed.), *The Cambridge Social History of Britain 1750-1950*, Vol.3 (Cambridge, 1990), pp.370-71.

<sup>93</sup> *Ibid.*, pp.370-73.

<sup>94</sup> Between 1839 and 1870 at least 130 'charity' schools were founded in Birmingham. See Skipp, *Victorian Birmingham*, pp.123-27.

<sup>95</sup> BCA, BMHW, HC/WH 1/10/4, General Statement of Income and Expenditure, Annual Report, 1901.

<sup>96</sup> *Ibid.*, HC/WH 1/1/1, Board of Governors, 4 December 1877.

<sup>97</sup> The principles of charitable funding of hospitals are fully discussed in K. Waddington, *Charity and the London Hospitals, 1850-1898* (London, 2000).

<sup>98</sup> BCA, BMHW, HC/WH 1/10/1, Annual Report, 1872.



classes'.<sup>100</sup> This led to the suggestion that 'if the workers of the town could be organized they would not be found wanting any more than their betters'.<sup>101</sup> The published accounts illustrate the truth of that statement. The first collection, in 1873, raised £4,705 11s 3d, just £664 17s short of the total raised by the Hospital Sunday collections in that year.<sup>102</sup> The sums received were not large, as the yearly amounts were divided among several hospitals, but there was a small increase year on year.<sup>103</sup> For example, the Hospital Saturday Collection allocated £144 to the hospital in 1881.<sup>104</sup> In 1883, this rose to £184 6s 8d and further increased, to £301 13s 9d, in 1889.<sup>105</sup> The working class also supported the hospital through local groups, for example, the Small Heath Football Club, or events sponsored by local employers, such as the charity Tug of War, organized by the Birmingham Small Arms Manufacturers which raised £161 12s 7d.<sup>106</sup> The Sparkbrook and District Amalgamated Friendly Societies were regular donors, and increased their contribution annually. By 1892, their contribution was such that the Institution publicly acknowledged that one of the in-patient beds was supported by the Society.<sup>107</sup> Other sources of income were ad hoc donations, legacies and income from investments.<sup>108</sup> At times of financial crisis, charity functions, such as amateur dramatic performances, concerts and even ice skating on

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<sup>99</sup> Ibid., HC/WH 1/10/4, General Statement of Income and Expenditure, Annual Report, 1901.

<sup>100</sup> Harman, *Showell's, Dictionary of Birmingham*, p.98.

<sup>101</sup> Ibid.

<sup>102</sup> Ibid., pp.98-9.

<sup>103</sup> Stephen Cherry has argued that there is a need to consider non-differential motives for workplace collections, ranging from conscious self-help through to the assertion of rights and demands for concessions or reform. See, S. Cherry, 'Hospital Saturday, Workplace Collections and Issues in late Nineteenth-Century Hospital Funding, *Medical History*, 40 (2000), pp. 461-88.

<sup>104</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, 5 July 1881.

<sup>105</sup> Ibid., 4 July 1882, HC/WH 1/10/3, Annual Report, 1889.

<sup>106</sup> Ibid., Annual Report, 1886, HC/WH 1/2/1, Management Committee, 1 June 1897.

<sup>107</sup> Ibid., HC/WH 1/2/2, Management Committee, 1 November 1898.



Edgbaston pond, were organized.<sup>109</sup> The money generated by such activities was quite substantial; for example, the ice skating raised £60, whilst a 'Theatrical' the following month raised a further £150.<sup>110</sup> Many fund-raising events were aimed at women, such as the Sale of Works organized in 1895. The list of patrons on that occasion was particularly distinguished. Hosted by the Countess of Dudley (then President of the Charity), the list of attendees included the names of five other female members of the nobility, three Ladies and the names of a further eight women from the county social elite.<sup>111</sup>

As Hilary Marland has suggested, the presence of the traditional ruling classes at fund-raising events often served to attract middle-class subscribers seeking social advancement. Furthermore, it provided an opportunity to forge a relationship between the newly rich urban commercial and professional groups and the county elite.<sup>112</sup> A further explanation may be a desire to emphasise the regional appeal of the hospital, as the aforementioned women represented counties from across the Midlands. Dismissive of purely altruistic motives for charitable giving, a number of historians have pointed to other potential advantages to benefactors of medical charities.<sup>113</sup> Adopting 'social exchange' theories from the social sciences, some historians have interpreted the philanthropic activities of businessmen, whether financial aid or professional services, 'as a self-interested activity in which accumulated

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<sup>108</sup> Ibid., HC/WH 1/10/4, General Statement of Income and Expenditure, Annual Report, 1901.

<sup>109</sup> Ibid., HC/WH 1/1/1, Board of Governors, 7 January 1879, 6 January 1880, 3 February, 1880.

<sup>110</sup> Ibid., 6 January 1880, 3 February 1880.

<sup>111</sup> Ibid., HC/WH 1/10/4, Annual Report, 1895.

<sup>112</sup> Marland, *Medicine and Society*, pp.140-41, Cavallo, *The Motivations of Benefactors*, p.52.

<sup>113</sup> L. Granshaw, *St Mark's Hospital, London. A Social History of a Specialist Hospital* (London, 1985), pp.16-23, Marland, *Medicine and Society*, pp.140-44.

status is a capital return on their investment'.<sup>114</sup> Reciprocity is also central to the argument that among merchants and tradesmen, there may have been an expectation that their support would bring business contacts their way, through friendships formed with other subscribers, or gaining contracts with the charities themselves.<sup>115</sup> Others have suggested that there were political advantages to be gained from active involvement in such voluntary societies.<sup>116</sup> Such advantages should not be over-stated. As Brian Harrison has noted, in the nineteenth century an MP's generosity towards local charities was usual or even expected.<sup>117</sup>

Adopting a more pragmatic approach, David Owen has proposed that 'with all its blind spots and its sins of social omission and commission, this was a humanitarian age'.<sup>118</sup> Certainly, there were a limited number of advantages to subscribers in Birmingham. As may be expected in an institution where the Chairman was a leading figure in the Birmingham Chamber of Commerce, the hospital was managed much as any other business enterprise.<sup>119</sup> Contracts to supply goods and services were competitive and value for money was expected. For example, in an attempt to reduce drug expenditure, tenders were invited for the contract to supply the 51 drugs most often prescribed. Four tenders were received and, after some negotiation, the cheapest was accepted.<sup>120</sup> Furthermore, there was little cache attached to being a subscriber. Few governors in Birmingham had the opportunity to vote in the

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<sup>114</sup> A. W. Gouldner, 'The Norm of Reciprocity: A Preliminary Statement', *American Sociological Review*, xxv (1960), pp.161-78. Cited Kidd, *Social History*, 21 (1996), p.184.

<sup>115</sup> Granshaw, *St Mark's Hospital*, p.20, Marland, *Medicine and Society*, pp.138-39.

<sup>116</sup> *Ibid.*

<sup>117</sup> B. Harrison, *Peaceable Kingdom. Stability and Change in Modern Britain* (Oxford, 1982), p.221.

<sup>118</sup> D. Owen, *English Philanthropy 1660-1960* (London, 1964), p.164.

<sup>119</sup> Smith, 'Chamberlain', p.2.

<sup>120</sup> BCA, BMHW, HC/WH 1/11/1, Board of Governors, 6 September 1881.

election of medical staff, a practice that Marland has proposed further added to the prestige of donors.<sup>121</sup> Traditionally, in Birmingham as elsewhere, the custom was for medical staff to canvas the whole body of subscribers, who then voted for the candidate of their choice. Abuse within this system had been a cause of concern to the Charity Commissioners since the early decades of the nineteenth century. As M. Jeanne Peterson has shown, in the London hospitals appointments were 'made on a variety of grounds, most of them unrelated to medical skill'.<sup>122</sup> Personal friendships, family connections or professional networks were the primary criteria for senior appointments. For example, of the 42 surgical appointments to the established London hospitals between 1800-1855, at least 32 were in-house appointments.<sup>123</sup> Notwithstanding the complicity of the professional elite in a system of nepotism and favouritism, many hospital medical staff favoured reform, such as 'public examinations, an open application system, or nomination by a committee of the hospital staff'.<sup>124</sup> Despite the potential advantages of such proposals, the Charity Commission concluded that they were unlikely to be adopted voluntarily by the governors. Thus, they avoided making any clear recommendations for reform in its *Report* to Parliament in 1840.<sup>125</sup>

Chamberlain was clearly aware that the usual practice of appointing medical staff did little to encourage appointment by merit. More often, it was a 'matter of private friendship', or quickly settled by 'promising the vote without

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<sup>121</sup> Marland, *Medicine and Society*, p.140.

<sup>122</sup> M. J. Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley and Los Angeles, California and London, 1978), p.141.

<sup>123</sup> *Ibid.*, p.142.

<sup>124</sup> *Ibid.*, p.150.

<sup>125</sup> 32<sup>nd</sup> *Report of the Charity Commissioners*, 1840, p.684. Cited *ibid.*



enquiring if the candidate was the best in the field'.<sup>126</sup> To resolve this, a different method of electing Acting Honorary Medical Officers was proposed. A Medical Appointments Committee was established with representatives of the Management Board, Medical Board and twenty subscribers, chosen annually by ballot of the whole governing body. By adopting this method, Chamberlain hoped that subscribers would feel a greater responsibility to examine the comparative value of candidates to the hospital they proposed to serve.<sup>127</sup> It would appear that the posts advertised attracted candidates of a high calibre. Eleven candidates applied, some of whom held degrees of Doctor of Medicine, as well as the requisite Fellowship of the Royal College of Surgeons (England). Following a ballot, Mr C.J. Bracey, Dr T. Savage, Mr Ross Jordan and Mr Lawson Tait were elected as Acting Honorary Surgeons to the hospital.<sup>128</sup> Of those appointed, Charles Bracey, Thomas Savage and Ross Jordan were well known and respected locally. Bracey had been Professor of Anatomy at Queen's Hospital and was now on the staff of the Children's Hospital. Ross Jordan (the brother of Professor Furneaux Jordan, Professor of Anatomy at Queen's Hospital), had been a surgeon at Queen's Hospital. He was noted for his 'natural geniality of spirit' and earned enormous respect for the way he coped with a 'most painful affliction' that was to result in amputation of his leg in later life.<sup>129</sup>

Less well known was the young Lawson Tait, who had been in medical practice in the town for less than a year. As suggested above, competition was keen for the posts and it is probable that the appointment of Tait caused

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<sup>126</sup> BCA, BMHW, HC/WH 1/10/1, Annual Report, March 1872.

<sup>127</sup> Ibid.

<sup>128</sup> Ibid., HC/WH 1/1/1, Board of Governors, May 29, 1872.



some resentment amongst the older members of the profession. Conversely, his election as Honorary Medical Officer served Chamberlain's purpose well. In his address at the public meeting (discussed above), Chamberlain and his colleagues made clear their expectation that the proposed hospital would lead to great advances in medical practice, notably in the field of abdominal surgery. As will be shown in Chapter Three, there were great differences in professional opinion as to the value of some abdominal operations. Many conservatively minded physicians were opposed to procedures they considered sometimes unnecessary and often fatal. More progressive (and usually younger), practitioners, argued that such developments could revolutionize medical practice.<sup>130</sup> Tait adhered to the latter school of thought. A pupil of Sir James Young Simpson, one of Scotland's leading surgeons, Tait had already established a reputation in the developing field of abdominal surgery.<sup>131</sup> Since arriving in Birmingham, he had taken every opportunity to impress upon the leading citizens of the town the possibilities innovative surgical procedures offered to ameliorate the suffering of women. His supreme self-confidence, combined with a proven technical skill would have made a favourable impression upon the equally forceful Chamberlain. Subsequent events were to prove that Chamberlain's faith in his protégé was fully justified. Tait's election to one of the coveted posts is indicative of the Governor's determination that neither prejudices nor natural aversion to

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<sup>129</sup> 'Ross Jordan', *Birmingham Focus and Places*, 5 (1893), copy held at the Birmingham Medical Institute.

<sup>130</sup> See J. Eliot Sewell, 'Bountiful Bodies: Spencer Wells, Lawson Tait, and the Birth of British Gynaecology', PhD thesis, John Hopkins University (1990), for an analysis of the two schools of thought on gynaecological surgery.

<sup>131</sup> Tait trained in Edinburgh and held a junior surgical position in Wakefield, before moving to Birmingham at the age of twenty-five. Within a year of his arrival he announced himself as a Consulting Surgeon and aligned himself to the campaign for a hospital for women. His early career is discussed in Chapter Three.

change would hinder the work the hospital would do. The Medical Appointments Committee became a permanent feature of the administration and it would appear that it remained true to its founding principles. Neither family connections nor personal friendships influenced the decisions of the committee. On the retirement of Thomas Savage, some twenty-six years later, there were three applicants for the vacancy: his son, Dr Smallwood Savage, Dr Mary Sturge, then employed at the hospital as an anaesthetist (who further had a letter of support from Mr George Cadbury), and Mr Edge, a surgeon who had no connection with the hospital. In the ensuing ballot, Mr Edge received 22 votes, Dr Savage, 7 votes and Dr Sturge 3 votes; Mr Edge was duly elected.<sup>132</sup>

In a further departure from the usual practice, subscribers did not have the power to nominate those people deemed 'fit subjects for relief'. Historians have argued that the 'governor's letter, was a privilege that gave prestige to the donor and was regarded as a natural *quid pro quo* for their support'.<sup>133</sup> Such a system was regarded by the Governors at the Women's Hospital as distasteful, noting that it could not 'be desirable that (women) should have to explain their complaints to any but the medical men who will attend them'.<sup>134</sup> Thus, there was a policy of open access to the out-patient department and initially both consultation and treatment were free. This policy proved to be not economically viable and there was an early decision to make a small charge for out-patient attendance, partly to cover the unexpectedly high costs of drugs and medical appliances, but also to prevent abuse. The result of this

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<sup>132</sup> BCA, BMHW, HC/WH 1/2/1, Minutes of the General Committee, 21 September, 2 November, 16 November 1897.

<sup>133</sup> Pickstone, *Medicine and Industrial Society*, p.11, Waddington, *Charity and the London Hospitals*, p.33.

was considered to be highly satisfactory. At the Annual Meeting (1873), it was reported that the fee was keeping away 'in a great measure, improper cases from the hospital', although the committee considered that there was 'still abuse of the charity (and) that persons who could afford to pay still received attention within its walls'.<sup>135</sup>

As Keir Waddington has noted, there was a growing concern in the 1870s, about the potential for charitable abuse in the London hospitals.<sup>136</sup> Similar concerns were being expressed by the medical charities in Birmingham. A request came from the Governors at the Queen's Hospital, to monitor attendance at the out-patient clinics, both by 'the pauper classes', and those who, by virtue of their position in life, should seek 'assistance at private consulting rooms'.<sup>137</sup> Investigations undertaken by the Charitable Organisation Society throughout 1877 appear to have uncovered some abuse, particularly from patients deemed able to pay the fee. For example, in November 1877, of 46 patients attending the clinics, 8 gave the wrong address, 30 were legitimate, 7 should have paid and 1 was doubtful.<sup>138</sup> Addressing the Annual Meeting, the Mayor (Joseph Chamberlain), said that he had no doubt that this matter would receive the attention of the committee but cautioned against the assumption that the cases referred to constituted abuse.<sup>139</sup> Mr Goodman (Vice President) concurred with this view. He thought they were going rather far in their efforts to check abuse and would very much regret any steps that would discourage the very people they were seeking to

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<sup>134</sup> BCA, BMHW, HC/WH 1/10/1, Annual Report, Appendix 1, 1872

<sup>135</sup> Ibid., Annual Report, 1873.

<sup>136</sup> Waddington, *Charity and the London Hospitals*, pp.87-88.

<sup>137</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, 4 June 1877.

<sup>138</sup> Ibid., 5 Nov 1877.

<sup>139</sup> Ibid., HC/WH 1/10/1, Annual Report, March 1873 .



aid.<sup>140</sup> It is possible that in some instances there was no deliberate intention to abuse the system, rather reluctance for women to discuss gynaecological disorders, even with those closest to them. On one occasion, it was discovered that a patient under the care of Tait was the wife of a bank manager. When it was pointed out that 'Lawson Tait's fee, privately, would have been 12 guineas', the husband explained that 'his wife's regular attendance at the hospital had been unknown to him' and offered to pay a fee.<sup>141</sup>

The abuse of out-patient departments, by the moderately 'well-to-do', was a problem experienced by many of the voluntary hospitals in Birmingham. The Charity Organisation Society (COS) argued that the indiscriminate distribution of benefits by medical charities was a major reason their facilities were abused. Moreover, the lack of restrictions placed on their services did little to encourage self-help amongst the working classes. The COS felt that this growing dependence on charitable bodies was largely responsible for the development of widespread poverty in some sections of society. The remedy, they suggested, lay in self-supporting provident dispensaries.<sup>142</sup> The Town Council took note of this and following a public meeting to discuss the issues involved, advised the Governors of a plan to establish a provident dispensary in Birmingham.<sup>143</sup> Like other medical facilities in the town, the Birmingham

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<sup>140</sup> Ibid.

<sup>141</sup> Ibid., 3 January 1882.

<sup>142</sup> H.F. Reichenfeld, 'The Birmingham Provident Dispensary, Hockley Branch 1877-1948. A Chapter in the Development of Community Medical Services', *Birmingham Historian*, 21 (Birmingham 2002), p.17. For a wider analysis of the dispensary movement see, J. Lane, *A Social History of Medicine. Health, Healing and Disease in England, 1750-1950* (London and New York, 2001), pp. 89-93., I. Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine*, 55 (1981), pp. 322-41.

<sup>143</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, 6 November 1877.



Provident Dispensary owes its existence to Sands Cox.<sup>144</sup> Cox bequeathed £12,000 for the establishment of three provident dispensaries in the town, to be run in accordance with the rules drawn up by the COS.<sup>145</sup> These required membership to be restricted to 'persons whose income is proved ... to be insufficient to pay for medical attendance at the usual charges and are not in receipt of Poor Law Relief'.<sup>146</sup> Members paid a regular monthly subscription, which entitled them to be seen by a medical officer of their choice and the services of a dispenser.<sup>147</sup> Of particular interest, in relation to this thesis, is the role Lawson Tait played in the activities of the Dispensary. Tait was one of the original members involved in the foundation of the Provident Dispensary, accepting the position of Honorary Secretary. He was actively involved in negotiations with the Sands Cox trustees to release the necessary funds to construct the Dispensary and continued to take an active part in the day-to-day running of the Institution. Tait took a particular interest in ensuring that qualified dispensers were employed to run the dispensary and that experienced, well-trained midwives were available to expectant mothers.<sup>148</sup>

The Committee invited comments from various sources, including medical charities. The Women's Hospital was supportive of the dispensary, providing that it was carried on 'without extraneous support'.<sup>149</sup> This is perhaps unsurprising; the Governors had long held the belief that 'there were many people who could pay something, but not able to pay sufficient to secure the

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<sup>144</sup> Sands Cox played a prominent part in the foundation of the Medical School, see Reinartz, 'Healthcare and the Second City', p.19.

<sup>145</sup> Reichenfeld, 'The Birmingham Provident Dispensary', p.18.

<sup>146</sup> Ibid.

<sup>147</sup> First Report of the Medical Committee of the Charity Organisation Society, p.11. Cited *ibid.*

<sup>148</sup> Ibid., pp. 19-20.

<sup>149</sup> BCA, BMHW, HC/1/1/1, Board of Governors, 4 June 1878.

best care'.<sup>150</sup> It was thought to be 'of the utmost importance that people who were comparatively well off should be able to seek from an institution (like theirs), the high class aid they could not get in any other way'.<sup>151</sup> As such, it was always the intention of the founders that the hospital would accommodate a wider social class than who would perhaps normally attend a voluntary hospital. As Chamberlain had pointed out at the first public meeting, there were many women who would be able to 'contribute in some degree to their maintenance while in hospital'.<sup>152</sup> Moreover, a precedent for pay beds had been set by The Hospital for Women, Soho Square, which began admitting paying patients in 1869.<sup>153</sup> It is likely that Chamberlain knew his constituency well. As will be shown in Chapter Four, there were a number of independent women in Birmingham able to pay a small fee. In addition, there were the 'surplus women' of the Victorian era; the 'impoverished gentlewomen, the wives, widows and daughters of professional men, and needy and overworked governesses' cited by the Governors of The Hospital for Women in Soho Square.<sup>154</sup> It was agreed that four of the eight beds available would be allocated to paying patients, the charge in all cases being twenty-one shillings per week.<sup>155</sup> Initially this arrangement seemed promising, by 1874, thirty-one patients, out of a total of fifty were fee paying.<sup>156</sup> This level was not maintained however; the numbers fell steadily throughout the 1880s and none is recorded in the statement of expenses between 1895 and 1901.<sup>157</sup> No

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<sup>150</sup> Ibid., HC/WH, 1/10/1, Annual Report, March 1873.

<sup>151</sup> Ibid.

<sup>152</sup> Ibid., Annual Report, March 1872.

<sup>153</sup> Moscucci, *The Science of Women*, p.93.

<sup>154</sup> Ibid., p.93.

<sup>155</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, May 1871.

<sup>156</sup> Ibid., HC/WH 3/1/1, In Patient Register 1871-1892.

<sup>157</sup> Ibid., HC/WH 1/10/4, General Statement of Income and Expenditure, Annual Report, 1901.

explanation was given for this in the minutes. However, unlike the hospital in Soho Square, which offered superior accommodation according to the fee paid, no special provision was made for private patients.<sup>158</sup> Nonetheless, it was perhaps surprising that the scheme was not successful; voluntary hospitals were becoming increasingly attractive to the lower middle classes, as they offered a higher standard of medical and nursing care than was attainable in private homes.<sup>159</sup> Waddington has shown that by the mid-1880s, paying beds were becoming more widely accepted in London and other major provincial towns and cities.<sup>160</sup> It is known that at least one surgeon, Lawson Tait, had established a successful private practice and was able to offer medical facilities equal to the hospital.<sup>161</sup> Thereby, it is possible that wealthier patients were referred directly to Tait, although this does not appear to have been a cause of friction between Tait and the governing body.

Brian Abel-Smith has argued that medical staff usually founded and controlled specialist hospitals, but this was not always so.<sup>162</sup> Moscucci has revealed the extent of lay control at the Hospital for Women, Soho Square and has suggested that the greatest difficulty lay in the question of who selected the cases for admission.<sup>163</sup> As was the practice in many voluntary hospitals, at Soho Square the Governors defined the criteria for admission, often excluding 'offensive and incurable cases', such as cancer patients.<sup>164</sup> In Birmingham, Governors and medical staff maintained a co-operative and

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<sup>158</sup> Moscucci, *The Science of Women*, p.93.

<sup>159</sup> Pickstone, *Medicine and Industrial Society*, p.151.

<sup>160</sup> By 1883, 34 hospitals in London were charging their patients: see, Waddington, *Charity and the London Hospitals*, p.89.

<sup>161</sup> J.A. Shepherd, *Lawson Tait, The Rebellious Surgeon (1845-1899)* (Lawrence, Kansas, 1980).

<sup>162</sup> B. Abel-Smith, *The Hospitals, 1800-1948: A Study in Social Administration in England and Wales* (London, 1964), p.27.

<sup>163</sup> Moscucci, *The Science of Women*, p.90.



cordial relationship, with their respective roles and responsibilities clearly defined. From the outset, medical staff selected patients for admission, according to clinical need, from those attending the out-patients clinics. The early In-patient Registers note only the diagnosis but it would appear that those with conditions amenable to surgery, regardless of the underlying cause, were given priority for admission.<sup>165</sup> Medical care and treatment will be discussed further in the following chapters. Suffice to note at this point that, by 1890, surgical procedures, including those for malignant conditions, are recorded in over 40 per cent of patients.<sup>166</sup>

The organization and management of the hospital was the responsibility of the Governors. Governance of the Institution was entrusted to those Governors elected at the Annual General Meeting to the Committee of Management. This consisted of the 'President, 2 Vice-Presidents, a Treasurer, Honourable Secretary, 3 Trustees and 18 members (9 ladies and 9 gentlemen)'.<sup>167</sup> That women were involved in charities was not unusual. Corresponding with Barbara Leigh Smith in the 1860s, Emily Davies wrote 'All over the country, there are Ladies Associations, Ladies Committees, Schools managed by ladies, Magazines conducted by ladies etc. etc'.<sup>168</sup> Women's charities were usually managed by women; for example, the Birmingham Ladies Association for the Care of Friendless Girls, which worked to prevent prostitution or repair the lives of those fallen, had an exclusively women's

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<sup>164</sup> Ibid.

<sup>165</sup> BCA, BMHW, HC/WH 3/1/1, Patient Registers 1871-1892.

<sup>166</sup> Ibid.

<sup>167</sup> Ibid., HC/WH 1/1/1, Board of Governors, May 1871.

<sup>168</sup> Emily Davies to Barbara Leigh Smith Bodichon, Jan. 14 (1863) Bodichon Papers, Girton College, Cambridge. Cited F.K. Prochaska, *Women and Philanthropy in Nineteenth-Century England* (Oxford, 1980), p.32.



Executive Committee.<sup>169</sup> Others, particularly the more traditional charities, such as the London Missionary Society, were managed exclusively by men. Prochaska has shown that, in the mid-Victorian years, mixed management committees were becoming more common, though they were still regarded by some as 'a new and difficult thing'.<sup>170</sup> As Chairman, it is probable that Arthur Chamberlain proposed mixed sex committees at the Women's Hospital although he may have been guided by his friend and fellow Governor, the Reverend Henry Crosskey. As mentioned above, Chamberlain worshipped at the Unitarian Church of the Messiah, where an important part of Crosskey's reformist agenda was a concern to improve the position of women.<sup>171</sup> Henry Crosskey and his wife Hannah were keen advocates of the equal rights of women to participate in public life. Central to Crosskey's argument was that God, in his wisdom, had created men and women with 'a harmonious union of masculine and feminine strengths and attributes'.<sup>172</sup> It followed that human society should utilize these complementary strengths and attributes in all positions and occupations in life, for 'the spirit and power of women are as much needed for guidance and direction as the spirit and power of men'.<sup>173</sup>

It would appear that Chamberlain adhered to this philosophy in his business life. In his obituary, it was stated: 'Incidentally, it may be mentioned that he was a warm advocate of the employment of women in business pursuits, and at his works in Bartholomew Street he had an office staff of

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<sup>169</sup> Y. Ikeda, 'Different Roads to Citizenship: Charity and Women in Birmingham 1870-1900', MA dissertation, University of Warwick, 1999.

<sup>170</sup> Prochaska, *Women and Philanthropy*, pp.31-32.

<sup>171</sup> H. Plant, 'Ye Are All One in Jesus Christ': 'Aspects of Unitarianism and Feminism in Birmingham, c.1869-90', *Women's History Review*, 9:4 (2000), p.722.

<sup>172</sup> Ibid.

<sup>173</sup> H.W.Crosskey, 'The Position of Women', *English Woman's Journal*, 6 (1861), pp.289-97.

ladies, including a cashier'.<sup>174</sup> It is probable that his colleagues at the hospital held similar views. As John Seed has shown, Unitarians tended to form cohesive communities, bound together by a complex network of kinship and partnerships.<sup>175</sup> This pattern is certainly evident in Birmingham; the families of Joseph Chamberlain and Timothy and Archibald Kenrick in particular were linked by marriage and business partnerships across several generations. Joseph Chamberlain (Junior) (previously married to Archibald Kenrick's daughter Harriet, but widowed in 1863), married Florence Kenrick in 1868. In August of that year, her sister Alice married a fellow member of the congregation, Charles Beale. In June 1870, Arthur Chamberlain married Louisa, twin sister of Florence.<sup>176</sup> These families were among the most influential businessmen in the town and, as a point of interest, the wealth of both families can be linked to the process of industrialization, described above. The Kenrick family, Iron Founders of Wynn Hall, Denbighshire came to Birmingham c1780, doubtless attracted by the growth in cast-iron industry. Joseph Chamberlain (Senior) came to Birmingham early in the nineteenth century and, with his brother-in law John Nettlefold, founded what was to become one of Britain's leading firms of screw-makers.<sup>177</sup> The wealth derived from factory owners and businessmen extensively funded many charitable institutions in the town and collectively, the Chamberlain and Kenrick families made the most important contribution to the Charity. The hospital also attracted support from the wider nonconformist community; for example, the

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<sup>174</sup> *Birmingham Post*, 22 October 1913.

<sup>175</sup> J. Seed, 'Theologies of Power: Unitarianism and the Social relations of Religious Discourse, 1800-50', in R. J. Morris (ed.), *Class, Power and Social Structure in British Nineteenth-Century Towns* (Leicester, 1986), pp .130-31.

<sup>176</sup> BCA, Church of the Messiah, 180, Register of Marriages, 1837-1926.

<sup>177</sup> Skipp, *Victorian Birmingham*, p.58-9.

aforementioned industrialist Samuel Lloyd was a Trustee of the Charity, whilst younger members of the Cadbury family took an active interest in the welfare of the patients.

The women of these families were represented on all the committees of the hospital and were noted for their regular attendance at meetings. Moreover, it would appear that they had the full support of the body of subscribers. The Chair of the influential House Committee was invariably a lady Governor and women frequently obtained the majority of seats in the elections for the Medical Appointment Committee. For example, of the 15 members elected to this committee in 1878, 11 were lady Governors.<sup>178</sup> It is unsurprising, therefore, that the hospital gained an early reputation for supporting women in their professional careers. The most significant example of this is the appointment of Dr Louisa Atkins to the position of Resident Medical Officer, in 1872, thought to be the first appointment of its kind in the country.<sup>179</sup> This appointment (discussed in Chapter Two), and that of a female dispenser in the same year, set a precedent for the continued appointment of female professional staff to the hospital. As will be shown, this tradition was to be maintained throughout the hospital's history.

The women Governors did not confine their activities to the 'softer' issues, such as the recruitment of staff and patient welfare however; their presence on the Committee of Management ensured that they were actively involved in every aspect of hospital life. A perennial problem for all members of the Management Committee was finance. It had been anticipated that day-to-day costs, such as salaries, medicines and equipment, would come from annual

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<sup>178</sup> BCA, BMHW, HC/WH 1//3/1, House Committee Minutes, 30 April 1878.



subscriptions and patients' fees. It was with some concern, therefore, that they reported in July 1872, that the expenditure on 'drugs and medical appliances' was already exceeding the resources of the hospital.<sup>180</sup> Part of the problem was the amount of work being undertaken. Within the first five months, 596 new patients attended the clinics, with many women then needing further, follow-up appointments.<sup>181</sup> This level of demand exceeded all expectations and was unmanageable in the current premises. The lease of the adjoining property was purchased in 1872, but the clinics remained overcrowded.<sup>182</sup> By 1875, between eighty to one hundred patients were attending the out-patient department each afternoon and it was evident that substantial new accommodation was required.<sup>183</sup> Appeals for a building fund were launched and, in 1878, new premises for the out-patient department were leased in Upper Priory.<sup>184</sup> In that same year, the in-patient wards transferred to the premises donated by Louisa Ryland in Stratford Road, Sparkhill.<sup>185</sup> Notwithstanding Ryland's generosity, £2,000 was needed to complete the refurbishment, and a further £1,000 required to erect separate accommodation for patients undergoing surgery for 'Ovarian and Kindred Tumors'.<sup>186</sup>

Faced with such enormous financial pressure, it is perhaps unsurprising that in June 1880, the Chairman had to report the 'serious indebttness of the hospital'.<sup>187</sup> The actual debt was £2,500 but, as Chamberlain pointed out, the

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<sup>179</sup> Ibid., HC/WH 1/10/1, Annual Report, March 1873.

<sup>180</sup> Ibid., HC/WH 1/1/1, Board of Governors, 2 July 1872.

<sup>181</sup> Ibid., HC/WH 1/10/1, Annual Report, March 1872.

<sup>182</sup> Ibid., HC/WH 1/1/1, Board of Governors, 3 September 1872.

<sup>183</sup> Ibid., 18 May 1875.

<sup>184</sup> Ibid., 7 May 1878.

<sup>185</sup> Ibid., 2 July 1878.

<sup>186</sup> Ibid., HC/WH 1/10/2, Annual Report, 1878, Supplementary Report.

<sup>187</sup> Ibid., HC/WH 1/1/1, Board of Governors, 1 June 1880.



serious financial position was largely due to the building programme. If this debt could be paid off, there would be no need to incur another.<sup>188</sup> It was decided that a great effort be made to clear the debt and Mrs Richard Chamberlain and Mrs Ratcliffe were charged with organizing a major fund raising project, with the aim of raising at least £500. It was decided to hold a Garden Fete in the grounds of Colonel and Mrs Ratcliffe's home. The gardens were celebrated for their beauty and it was thought that they would attract many people not especially interested in the hospital. Among the attractions at the fete there were to be concerts, lectures, the sale of flowers and plants and refreshments.<sup>189</sup> Subsequently, with the proceeds of the fete and smaller charity events, like a football match which raised £20 4s 6d, plus 'lots of small donations of £100 or more', Chamberlain was able to report that the hospital was now out of debt.<sup>190</sup> As discussed above, historians have suggested that such occasions were largely an exercise in social advancement. Nevertheless, the amount of work involved in organizing such events was tremendous and required a good deal of commitment from all those involved. We know from the records of the Church of the Messiah, that many of those most active in hospital life were relatively young. For example, Arthur Chamberlain was 30 years old, and Alice Beale just 27 years, when the hospital opened in 1872.<sup>191</sup> It may be expected that these young people could have found less demanding ways of spending their time. Furthermore, in an age before formal codes of governance, it is evident that the Governors took personal responsibility for their actions. In July 1900, Chamberlain noted

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<sup>188</sup> Ibid., 23 June 1880.

<sup>189</sup> Ibid.

<sup>190</sup> Ibid., 2 November 1880.

<sup>191</sup> Ibid., Church of the Messiah, 180, Register of Marriages, 1837-1926.

that the Institution still held railway stocks, amounting to £2,148 13s 8d. bought on his advice when he was Secretary. The company now being in the hands of the Receiver, the bond's value had fallen to £20 each.<sup>192</sup> In a letter to the Treasurer, Chamberlain explained that 'he felt somewhat responsible' and offered to make good the loss, which amounted to some £2,000. The offer was quietly accepted, 'with the best thanks of the Committee'.<sup>193</sup>

The number of women seeking treatment continued to grow and, by 1903, approximately 450 in-patients were being treated each year; in addition, each surgeon had around 100 cases on their waiting list.<sup>194</sup> The year-on-year increase in demand meant that the hospital was again overcrowded and, despite further extensions, the building was no longer fit for purpose. A freehold site in Showell Green Lane, Sparkhill, was purchased for a new 50-bed hospital and adjacent convalescent home. In 1904, Arthur Chamberlain, then President of the hospital, laid the foundation stone and took the opportunity to remind his audience of the principles that underpinned the Institution. They were there to serve those women whose disease was not caused by vice or the self-indulgence of the sufferers, but by the unfortunate conditions under which women, forced to cope with their circumstances by their own efforts, had to earn a living.<sup>195</sup> Chamberlain spoke also of the progress that the hospital had made since the Institution started. Over 36,000 women had been treated, which amounted to an average of 4,250 per year. He recalled that the population of Birmingham was 370,000 when the hospital was founded and reminded his listeners that it then stood at 533,000; he

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<sup>192</sup> Ibid., BMHW, HC/WH 1/2/1, Management Committee, 10 July 1900.

<sup>193</sup> Ibid.

<sup>194</sup> Ibid., HC/WH 1/10/5, Annual Report, April 1904.

<sup>195</sup> Ibid.

understood that there was an even greater increase in surrounding districts.<sup>196</sup> Thus, there was an urgent need for a new hospital and he was hopeful that the improved facilities would further aid the medical care their patients received.<sup>197</sup> As will be shown in the following chapters, the hospital was to remain at this site throughout our period, although later developments in medical treatment ensured that frequent adaptations and further extensions were required. The work of the governing body was by no means complete.

In conclusion, the purpose of this chapter has been to describe the founding of the Women's Hospital. The aim has been to establish the principles on which the Charity was established and the underlying ethos of the hospital. In particular, an attempt has been made to assess the motivations of the hospital's founders and supporters, a task made more challenging by the wealth of scholarship in this area. A criticism often applied to Victorian charity is the claim that philanthropists failed to challenge the inequalities inherent in the social structure. This pre-supposes that they accepted the status quo, yet many philanthropists were also active in social reform.<sup>198</sup> As Owen has acknowledged, to try to explain Victorian philanthropy raises all sorts of unanswerable questions, but few would discount the influence of religion on philanthropy's advance.<sup>199</sup> There can be few towns in Britain where this is more evident than Birmingham. It was the clarion call of George Dawson and other nonconformist ministers such as R.W. Dale, that spurred nonconformist families, like the Chamberlains, Kendricks, Martineau and Nettlefolds to work with all their accumulated

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<sup>196</sup> Ibid.

<sup>197</sup> Ibid.

<sup>198</sup> Harrison, *Peaceable Kingdom*, p.223.

<sup>199</sup> Owen, *English Philanthropy*, p.164.

energy to build a town that would be worthy of their faith and calling. Alongside them were the Quaker families, like those of Lloyd, Cadbury and Sturge, who were particularly active in social reform, notably the Adult School movement. They were families conscious of their birthright and the social responsibility that this entailed.<sup>200</sup> Local initiatives, such as the Improvement Scheme to demolish the area in the centre of the town described by the *Birmingham Mail* as 'a sort of place which was shown to visiting philanthropists as a specimen of our slums' or the building of schools and hospitals, were never divorced from Christian worship.<sup>201</sup> Similarly, the doctrine behind the civic gospel guided the way the Institution progressed.

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<sup>200</sup> Briggs, *History of Birmingham*, pp 1-2.

<sup>201</sup> *Birmingham Mail*, 1 January 1879. Cited *ibid.*, p.19.



## Chapter 2

### *Lady Physicians and Female Pharmacists*

#### *Women in Medicine*

This chapter expands a theme briefly referred to in the previous chapter, the important role that women played in establishing health care facilities for women in Birmingham. We have seen how women from the leading nonconformist families in the town worked with their husbands, fathers and other male relatives on the governing body of the Institution. Their efforts were given willingly, in what they believed to be a worthwhile cause and, as will be shown below, the Governors were also supportive of middle-class women seeking to earn their living by means of a professional career. Brief mention was made in Chapter One of the appointment of a lady doctor. Female practitioners were to become an integral part of the medical team of the Institution; how this practice was introduced and developed is explored below. Nationally, the cause of women seeking a career in medicine had a high profile and their battle for education and training has been well documented by historians.<sup>1</sup> Less attention has been paid to the efforts by the women's movement to find suitable positions for other middle-class women of 'refined manners' seeking suitable employment. Dispensing, in voluntary hospitals or Poor Law institutions, offered one such opportunity and one that the Women's Hospital was to embrace. It will be argued that such careers

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<sup>1</sup> S. Roberts, *Sophia Jex-Blake. A Pioneer in Nineteenth-Century Medical Reform* (London and New York, 1993), T. N. Bonner, *To The Ends Of The Earth. Women's Search for Education in Medicine* (Cambridge, Mass. and London, 1992), J. Manton, *Elizabeth Garret Anderson* (London, 1965), E. Moberly Bell, *Storming the Citadel. The Rise of the Woman Doctor* (London, 1953).

had real benefits, both for a particular group of women and as a positive contribution to patient care.

As mentioned in the previous chapter, from the first conception of a special hospital for women Arthur Chamberlain and his colleagues hoped that it would take a lead in the advance of gynaecological surgery. Not all hospitals for women took the path to surgical intervention however; female-run institutions often adopted a more holistic style of medicine. Women doctors, like the American physician Elizabeth Blackwell, maintained that you could not differentiate between the spiritual and the physical and advised her students to look beyond the 'narrow limits of sensation'.<sup>2</sup> In accordance with the more holistic approach to disease that was still current in the later decades of the nineteenth century, Blackwell argued that the physician had more to do than to cure the body and proposed that women were uniquely suited to this wider role.<sup>3</sup> Like many female physicians, Blackwell believed that women had more patience and sensitivity in dealing with patients and a greater insight into the social and environmental factors in illness. Her therapeutic style reflected this and she placed greater emphasis on the prevention of ill health, rather than cure.<sup>4</sup> In contrast, Dr Mary Putnam Jacobi, another leader amongst her generation of women physicians, had a very different view. Jacobi had 'a love of scientific rationalism' and enthusiastically embraced the modern and empirical world of professional medicine.<sup>5</sup> She argued that the greatest

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<sup>2</sup> R. Morantz-Sanchez, 'The Gendering of Empathic Expertise: How Women Physicians Became More Empathic Than Men', in J. Walzer Leavitt (ed.), *Women and Health in America* (2nd ed. 1999) (Wisconsin, 1984), E. Blackwell, 'The Influence of Women in the Profession of Medicine', in *Essays in Medical Sociology* (London, 1902) (reprinted New York, 1972), vol. 2, pp. 5-6, 12. Cited R. Morantz-Sanchez, *Sympathy and Science. Women Physicians in American Medicine* (New York and Oxford, 1985), p.190.

<sup>3</sup> *Ibid.*, pp.189-90.

<sup>4</sup> *Ibid.*, p.211.

<sup>5</sup> *Ibid.*, p.185.

difficulty in medicine lay with 'the great mass of facts, which it is necessary to know' and 'the variety of sciences, which must be understood to interpret these facts'.<sup>6</sup> Thus, these two pioneering women doctors had very different therapeutic approaches, which reflected wider debates about the development of scientific medicine. These issues had significant consequences for the development of gynaecological surgery and will be discussed further in Chapter Three. The aim in this chapter is to explore the different therapeutic approaches to the health of women. We begin by reviewing the battle by women to enter the profession of medicine.

The election of Dr Louisa Atkins to the medical staff at the Women's Hospital, Birmingham, in July 1872, was thought to be the first such appointment; of particular interest is the timing of that appointment. The question of women in medicine was perhaps the most controversial issue facing the medical profession in the middle decades of the nineteenth century. Although there was nothing in the wording of the 1858 Medical Act to legally exclude them, women were effectively denied entry to the Medical Register and thereby the right to engage in 'legitimate medical practice'.<sup>7</sup> As Anne Witz has shown, the refusal of the medical faculties of universities and boards of examiners to allow them access to medical education and training underpinned the male monopoly of the profession.<sup>8</sup> The enabling legislation of the 1876 Medical Act finally allowed five British women, who had obtained their degrees in Europe, to be admitted to the Medical Register.<sup>9</sup>

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<sup>6</sup> Ibid., p.196.

<sup>7</sup> A. Witz, *Professions and Patriarchy* (London, 1992), p.73.

<sup>8</sup> See ibid, Chapter 3, for a full discussion of the exclusionary tactics adopted by the medical hierarchy.

<sup>9</sup> The Medical Act (Qualifications), 1876, extended the powers of examining bodies to grant qualifications for registration, to all persons without distinction of sex. The Dublin College of



Nonetheless, the position of women doctors improved only slowly, in part due to the permissive status of the legislation. Many institutions delayed its implementation, including the Royal College of Surgeons, who steadfastly refused to do so until 1908 and the Royal College of Physicians, who finally admitted women in 1909.<sup>10</sup> This strategy circumscribed women's career choices; for example, fellowship of the Royal College of Surgeons was a requirement for many surgical posts, as indeed it was at the Women's Hospital.<sup>11</sup> Faced with such obstacles, women followed the example of those male doctors, who had successfully pursued professional advancement through specialization. They created their own career paths, by establishing hospitals specifically for the treatment of women, or women and children. Elizabeth Garrett (later, Garrett Anderson) was the pioneer in this movement. Garrett opened St Mary's Dispensary for Women and Children, Marylebone, in 1866.<sup>12</sup> The timing of this initiative was fortunate; in the summer of that year there had been outbreaks of cholera in Britain, including several episodes in the East End of London. Memories of earlier outbreaks of the disease, held to be the most dreaded disease of the nineteenth century, were sufficiently fresh in the minds of many Londoners to create an atmosphere of panic.<sup>13</sup> In such a climate, hostility to women doctors was forgotten,

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Physicians was the first to do so in 1877. For a fuller discussion on the passage of the 1876 Bill, see *ibid.*, pp.92-100.

<sup>10</sup> Both Colleges passed bye-laws prohibiting women from taking part in the government of the college, this was not amended by the College of Physicians until 1925. *Ibid.*, p.100.

<sup>11</sup> Birmingham City Archives (hereafter BCA), Archives of The Birmingham and Midland Hospital for Women (hereafter BMHW), HC/WH 1/10/1, Annual Report, 1872.

<sup>12</sup> Manton, *Elizabeth Garrett Anderson*, p.173.

<sup>13</sup> Outbreaks of cholera occurred in London in 1831, 1847 and 1853. Memories of the hideous nature of the disease and its rapid spread, created widespread panic throughout the population. See D. Porter, 'Public Health', in W.F. Bynum and R. Porter (eds), *Companion Encyclopaedia of the History of Medicine* (London, 1993), Volume 2, Chapter 51, C.E. Rosenberg, *Explaining Epidemics and Other Studies in the History of Medicine* (Cambridge, 1992), Chapter 6, for an overview of this subject.



particularly towards one proposing to open a dispensary in a poor and densely crowded part of London. Garrett's proposal was thus generally well received within the medical profession. At the opening ceremony, Dr Billings, FRS, former Professor of Medicine at the London Hospital, spoke warmly of the knowledge and skill of 'the first legally qualified female practitioner which England can boast'.<sup>14</sup> Garrett had thus established the principle of a dispensary for women staffed by women and this modest venture grew into the New Hospital for Women, which opened in 1872.<sup>15</sup>

Similarly, on the successful conclusion of the long campaign to permit women to pursue a career in medicine, Sophia Jex-Blake returned to Edinburgh to establish her own practice.<sup>16</sup> In 1878, Jex-Blake opened The Edinburgh Provident Dispensary for Women and Children that was expanded into a small cottage hospital in 1885.<sup>17</sup> Others, such as Eliza Walker Dunbar, followed their example and by the outbreak of World War I, there were fifteen hospitals for women, founded or staffed by medical women.<sup>18</sup> The significance of women run hospitals, and the impact they had on the health of women, has been the subject of much scholarly debate. Historians have pointed to the limited facilities available in such small institutions, notably in the early years.<sup>19</sup> Jex-Blake's hospital, for example, largely treated the chronic, functional complaints of women and rest and nourishment was an

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<sup>14</sup> Manton, *Elizabeth Garrett Anderson*, p.174.

<sup>15</sup> M. A. Elston, 'Run by Women (mainly) for Women: Medical Women's Hospitals in Britain, 1866-1948', in L. Conrad and A. Hardy (eds), *Women in Modern Medicine* (Amsterdam, 2000), p.73.

<sup>16</sup> See Roberts, *Sophia Jex-Blake*, for a full account of Jex-Blake's battles for medical education for women in Edinburgh and London.

<sup>17</sup> E. Thomson, 'Women in Medicine in Late Nineteenth and Early Twentieth Century Edinburgh: A Case Study', PhD thesis, University of Edinburgh, 1998.

<sup>18</sup> Elston, 'Run by Women (mainly) for Women', p.76.

essential part of their care.<sup>20</sup> The importance of such hospitals to the professional careers of female practitioners is more certain and this object was clearly stated in literature aimed at medical women and committed feminists.<sup>21</sup> In appeals aimed at a wider audience, greater emphasis was placed on the benefits women would accrue by having a hospital staffed by qualified female professionals. It was held that women's natural modesty often prevented them from seeking help from male doctors, whereas the holistic approach of female practitioners was more in tune with their sensitivities.<sup>22</sup> Implicit in such arguments was the notion that 'women needed women physicians to understand their ailments best'.<sup>23</sup>

Elizabeth Blackwell was perhaps the most influential proponent of the ideology of domesticity that underpinned this approach. Speaking of her moral reformist agenda in 1889, she wrote 'The progress and welfare of society is more intimately bound up with the prevailing tone and influence of the medical profession than with the status of any other class of men.'<sup>24</sup> As such, Blackwell expected women physicians to use their unique qualities to work towards the wider goals of ensuring human beings were 'well born, well nourished and well educated'.<sup>25</sup> Others, such as Jacobi, disdained this moral platform and rejected the feminist emphasis on 'women's qualities'. Regina Morantz-Sanchez has described her as a woman of keen intellect which 'cut

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<sup>19</sup> B. Harrison, 'Women's Health and the Women's Movement in Britain: 1840-1940', in C. Webster (ed.), *Biology, Medicine and Society* (London, 1981), pp.15-71. Thomson, 'Women in Medicine', Elston 'Run by Women (mainly) for Women'.

<sup>20</sup> Thomson, 'Women in Medicine in Late Nineteenth and Early Twentieth Century Edinburgh', p.181 ff

<sup>21</sup> Elston, 'Run by Women (mainly) for Women', p.77.

<sup>22</sup> Ibid., pp.77-78.

<sup>23</sup> Morantz-Sanchez, *Sympathy and Science*, p.210.

<sup>24</sup> Blackwell, 'The Influence of Women in the Profession of Medicine', pp.5-6, 12. Cited *ibid.*, p.185.

<sup>25</sup> Ibid., p.60.

to the core of things with a rapidity that left lesser minds bewildered'.<sup>26</sup> Whilst Jacobi could sympathise with Blackwell's evident difficulties with the theoretical reading of medicine, she could not excuse her neglect of the subject, or her intense indifference to the practical aspects of clinical medicine.<sup>27</sup> It is probable that women physicians, such as Louisa Atkins, who chose to work in the larger integrated professional network were closer to Jacobi's position on the professional assimilation of women, rather than to the separatist stance adopted by Blackwell and others.<sup>28</sup>

Atkins had a promising start to her professional career, gaining clinical experience at Elizabeth Garrett's Dispensary in London. Along with two other young women, Frances Morgan and Eliza Walker Dunbar, Atkins had intended to take the same circuitous route to registration as her mentor.<sup>29</sup> This plan was thwarted when a decision was taken by the Society of Apothecaries in 1868, to revise its constitution specifically to exclude women from its examinations.<sup>30</sup> Frustrated in their attempts to complete their medical education, the women took Garrett's advice and continued their studies in Zurich, Atkins eventually gaining her Diploma in 1872. Thus, although not yet able to be admitted to the Medical Register, she was in a position to respond to the advertisement for a Resident Medical Officer (RMO) at The Women's Hospital in that same year. Three candidates applied for the post and the Medical Board met, as required, to confirm that their qualifications met the legal requirements. The diplomas of the two male applicants were confirmed

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<sup>26</sup> Ibid., p.185.

<sup>27</sup> Ibid., pp.185-86.

<sup>28</sup> See *ibid.*, chapter 7, for a comprehensive analysis of the careers of Blackwell and Jacobi as representative types of women physicians.

<sup>29</sup> Anderson became a licentiate of the Society of Apothecaries to enable her register as MD. A full account is given in Manton, *Elizabeth Garrett Anderson*.



and it was noted that Atkins had a diploma from the University of Zurich, stating that it had been obtained after examination. When asked for their judgement on her qualifications, the Medical Board were 'unable to state whether the studies she had undertaken would be considered sufficient to any body which might at sometime consent to examine women'.<sup>31</sup> Nevertheless, they agreed that she appeared to have covered the required curriculum and that her testimonials confirmed her competence.<sup>32</sup> The matter was then referred back to the Management Committee, with whom the final decision lay. Atkins was subsequently offered the position of RMO at the hospital.<sup>33</sup> In their Report to the Annual Meeting (1873), the Committee justified their action thus:

In reply to this advertisement, the Committee received various applications and from among the candidates reported by the Medical Board to possess the necessary qualifications, the Committee unanimously chose Dr. Louisa Atkins, who had just passed her final examination after four and a half years study. Your Committee call the attention of subscribers to this step: it was not taken until, after long and grave deliberations which were rendered the more difficult from the fact that this was the first appointment of a lady doctor to a similar post in this country. Your Committee, however, have now the pleasure to report that they have every reason to be satisfied with the appointment they have made. It is a matter of regret to them that the English Medical Faculty will not admit

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<sup>30</sup> Ibid., p.176.

<sup>31</sup> BCA., BMHW, HC/WH 1/5/1, Medical Board, 16 July 1872.

<sup>32</sup> Ibid.

<sup>33</sup> Ibid., HC/WH 1/1/1, Board of Governors, 23 July 1872.



ladies to their examinations, as they thus prevent their obtaining in this country legal recognition of their qualifications.<sup>34</sup>

This bold statement clearly reflects the Committee's sentiments on the position of women but it is probable that it was a view shared amongst others in the town. In 1871, Birmingham was one of the boroughs where all three members voted in favour of the Bill to extend the franchise to women. Although the Bill failed, support for the cause remained strong and in January 1874 the town hosted a conference held by the National Society for Women's Suffrage.<sup>35</sup> Thus, the campaign for women to enter medicine attracted considerable interest in Birmingham. In June 1873, an association was formed, under the patronage of Lady Lyttleton, to promote the education of women in the medical profession.<sup>36</sup> Specifically, its objectives were to 'obtain the admission of women as students of medicine into the Queen's College, Birmingham (and) to obtain permission for medical students into the hospital of Birmingham for the purpose of medical practice'.<sup>37</sup> At the inaugural meeting, addressed by Louisa Atkins and her friend and former colleague Eliza Walker, it was proposed that separate classes for female students be arranged, to be supported by a grant of £100 from the association.<sup>38</sup> At a meeting of the Professors of Queen's College, held two days later, even this modest proposal was refused. A resolution, passed by twelve votes to seven,

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<sup>34</sup> Ibid., HC/WH 1/10/1, Annual Report, 1873.

<sup>35</sup> BCA, LP 22.7, CRA, SIS collection, E. Crawford, *From Frederick Street to Winson Green. The Women's Suffrage Movement in Birmingham 1866-1918* (London, 2000).

<sup>36</sup> *Englishwoman's Review*, new series, 4 (1873), pp.226-27.

<sup>37</sup> Ibid., p.227.

<sup>38</sup> Ibid.

concurred with an earlier decision by council against the admission of female students to the college at present.<sup>39</sup>

Notwithstanding this disappointing outcome, more than half of the medical staff canvassed had voted in favour of the resolution; it is also highly probable that such proposals would have met with Lawson Tait's approval. On his appointment as lecturer in physiology and biology at the Midland Institute, one of his first initiatives was to institute a special class for ladies.<sup>40</sup> Tait's support for women's education may have been informed by his experiences in Edinburgh, as he was undertaking his medical training at the extra-mural school of Edinburgh University whilst Elizabeth Garrett was a student there. It is likely that Tait was acutely aware of the difficulties she was facing; he would also have had knowledge of the encouragement his teacher and mentor, Sir James Young Simpson, gave the young Elizabeth.<sup>41</sup> Tait had always taken a keen interest in medico-political affairs, notably the medical education of women. He spoke at length on the subject and said that Birmingham, 'with its support of free trade should be liberal in its views'.<sup>42</sup> There is little doubting Tait's sincerity; he took the trouble to go to Zurich where he observed lectures attended by female medical students, noting that that 'there was not the least embarrassment' when diseases 'peculiar to the male' were discussed in their presence.<sup>43</sup> It has also been reported that Tait employed a lady anaesthetist for many years in his private practice.<sup>44</sup> These actions are strangely at odds with Tait's firm belief in the Darwinian theory of natural selection. Whilst he

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<sup>39</sup> Ibid.

<sup>40</sup> J.A. Shepherd, *Lawson Tait. The Rebellious Surgeon (1845-1899)* (Lawrence, Kansas, 1980), pp.39-40.

<sup>41</sup> Ibid., pp.4-5.

<sup>42</sup> Ibid., p.39.

<sup>43</sup> Ibid., pp.39-40.

declared himself 'an advanced advocate of women's rights' he could not help 'seeing the mischief women will do to themselves and the race generally, if they avail themselves too fully of these rights when conceded'.<sup>45</sup> Tait argued that if middle-class women neglected their natural role as wife and mother in favour of a college education, they would 'rob the human race of what it wants most, brain power on the part of the mother. To leave only the inferior women to perpetuate the species will do more to deteriorate the human race than all the individual victories at Girton will benefit it'.<sup>46</sup> Notwithstanding these arguments, published in 1883, it is likely that Tait was more widely known for his liberal views on the medical education of women. It is probable that this is what encouraged Atkins to apply to the Women's Hospital and almost certainly influenced the thinking of her successor, Edith Pechey.

It was the appointment of Pechey in 1875 that perhaps best underlines the hospital's commitment to the employment of female medical practitioners. Pechey had studied in Edinburgh, being one of the first in 1869 to join Jex-Blake at that university and had continued her studies at the newly founded London School of Medicine for Women in London.<sup>47</sup> However, the ultimate success of the School was dependent on it being recognized by at least one of the accredited examining boards, all of whom flatly refused to admit women to their examinations.<sup>48</sup> Nonetheless, some encouragement could be gleaned from the statement issued by the General Medical Council in 1875 that it was

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<sup>44</sup> Ibid., p.39.

<sup>45</sup> R.L.Tait, *The Pathology and Treatment of Diseases of the Ovaries* (4th ed.) (Birmingham and New York, 1883), p.91.

<sup>46</sup> Ibid.

<sup>47</sup> The London School of Medicine for Women opened in 1874. A full account of the history of the school is given in Roberts, *Sophia Jex-Blake*, p.138 ff

<sup>48</sup> Witz, *Professions and Patriarchy*, p.92.

'not prepared to say that women ought to be excluded from the profession'.<sup>49</sup> Tentative proposals had been put forward by the Medical Council for a 'different but equivalent qualification' for women. To this end, Pechey, Jex-Blake and Isabel Thorne sought a qualification that would enable them to be admitted to the Medical Register.<sup>50</sup> Such an opportunity presented itself in the examination for a Licence in Midwifery, offered by the Royal College of Surgeons in England. Having prepared for the examination, and meeting all of the College's requirements, the three women were formally accepted as candidates for the examination. At the last moment, they were informed that the examination had been cancelled. Opposing factions within the College, unable to find legalistic grounds for refusing the women's application, had persuaded the three examiners to resign to signify their protest.<sup>51</sup>

After the debacle of the midwifery examinations, the future of the London School of Medicine was in doubt. Some students chose to continue their studies abroad; others found opportunities nearer to home.<sup>52</sup> Shirley Roberts has noted that Pechey found an opening in Birmingham, 'where she was permitted to work under the supervision of the eminent surgeon, Mr Lawson Tait'.<sup>53</sup> In her application to the Women's Hospital, Pechey submitted certificates of attendance at Edinburgh, where she had been an outstanding student and the London School of Medicine for Women. Nonetheless, she was not qualified and it needed a somewhat liberal interpretation of the Institution's stated requirement, that applicants 'must have obtained, or be in a

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<sup>49</sup> S. Jex-Blake, *Medical Women* (London, 1886), p.190. Cited Roberts, *Sophia Jex-Blake*, p.150.

<sup>50</sup> *Ibid.*, pp.150-51.

<sup>51</sup> *Ibid.*, pp.151-52.

<sup>52</sup> *Ibid.*, p.152.

<sup>53</sup> *Ibid.*



position to obtain, their Diploma' to overcome this deficiency.<sup>54</sup> It is clear that the Governors kept abreast of national issues; articles in the *Lancet* and other medical journals are regularly cited in the minutes of their meetings. All parties, therefore, were cognizant of the difficulties faced by women aspiring to be doctors. By mutual consent, both Governors and medical staff agreed that although not yet technically qualified, it appeared to them a 'question of competence'.<sup>55</sup> They concluded that Pechey's 'certificates and testimonials appeared to guarantee this (and) they had no hesitation in appointing Miss Edith Pechey to the vacant post of House Surgeon'.<sup>56</sup>

The united position of Governors and Medical Staff on this issue, at a time when prejudice against female practitioners was widespread within the profession, is of particular interest. In 1873, the medical staff of Bristol Children's Hospital had threatened to resign *en bloc* in protest at a proposal to elect Dr Eliza Walker to the post of House Surgeon.<sup>57</sup> Attempts had been made in 1875 and again in 1876 to introduce a Bill to secure women's access to the medical register by proposing that foreign degrees were to be recognized but only when they were held by women. This was opposed on the grounds that it sought to treat women more favourably than men. A second attempt to secure the legal rights of women was being pursued in tandem; this was the Medical Act (Qualifications) Bill of 1876 'for enabling Examining Bodies to treat their charters and statutes as not being limited to one sex, but as applying to both'.<sup>58</sup> This Bill was passed at its second reading but it had its limitations; its weakness lay in the fact that it was only

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<sup>54</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, 6 July 1875.

<sup>55</sup> *Ibid.*, 31 July 1875.

<sup>56</sup> *Ibid.*

<sup>57</sup> *Englishwoman's Review*, new series, 4 (1873), p.227.

enabling legislation and did not compel anyone to act upon it.<sup>59</sup> Moreover, the 1876 Act did little to soften attitudes; when the British Medical Association (BMA) canvassed its members on the admission of women doctors in 1878 three to one voted against women.<sup>60</sup> In contrast, after the difficulties of Pechey's appointment were overcome, women's place on the medical staff at the Women's Hospital was assured. The establishment of a permanent position, for a senior female medical practitioner, further consolidated their position. The opportunity arose when a decision was made to increase the number of medical staff to cope with the workload. Since the opening of the new out-patient department in July 1878 the number of patients attending the hospital had risen significantly.<sup>61</sup> The Medical Board acknowledged that the out-patient clinics were overcrowded and the waiting lists for surgery unacceptably long. It was evident that more staff were needed and it was decided that two additional posts be created. The first was for a Lady Physician and the second post was designated Assistant Surgeon. Prospective applicants for both positions were required to be on the Medical Register, applicants for the surgical post were additionally required to be Fellows of the Royal College of Surgeons (FRCS).<sup>62</sup>

The delaying tactics, described above, employed by the Royal College of Surgeons in implementing the 1876 Medical Act ensured that women were not eligible for the surgical post, although they could be confident in their application for the post of physician. Dr Annie Barker, previously employed as House Surgeon at the hospital, was subsequently appointed to this post in

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<sup>58</sup> *Hansard CCXXX 1876: 1003. Cited Witz, *Professions and Patriarchy*, p.94.*

<sup>59</sup> *Ibid.*, pp. 94-95.

<sup>60</sup> Manton, *Elizabeth Garrett Anderson*, p.258.

<sup>61</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, 7 May 1878.

July 1878.<sup>63</sup> Barker remained at the hospital until 1883 when Dr Annie Clarke, who had also previously worked at the hospital, replaced her.<sup>64</sup> Following her return, as Honorary Medical Officer, Clarke was to remain at the hospital throughout her professional career.<sup>65</sup> A further senior appointment was that of consultant anaesthetist, Dr Mary Sturge, who also remained on the staff until her retirement. That women sought permanent posts at the Women's Hospital, under the government and instruction of men, suggests that they did not necessarily share the view that 'women-run hospitals were more appropriate to women's needs than that provided in male or mixed-staff hospitals'.<sup>66</sup> Many medical women adhered to this ideology, notably in North America, where gender separatism was more evident but even in the United States distinctions in therapeutic practice, between male and female practitioners, were not universally accepted. As noted above, Jacobi's ambition was to be a first-rate physician and scientist and she found great satisfaction in succeeding in the scientific world of male medicine.<sup>67</sup> Her contemporary, Mary Dixon Jones could also 'speak the language of science'.<sup>68</sup> Morantz-Sanchez has described her as 'a clinician who understood the new science and could use it at the bedside'.<sup>69</sup> She published extensively, citing the works of others and contributing to the current debates within the field. Following Lawson Tait, with whom she corresponded regularly, Dixon Jones advocated early surgery; indeed, her surgical career

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<sup>62</sup> Ibid., HC/WH 1/5/1, Medical Board, 31 May 1878.

<sup>63</sup> Ibid., HC/WH 1/1/1, Board of Governors, 2 July 1878.

<sup>64</sup> Ibid., 2 July 1878 and 16 September 1879.

<sup>65</sup> Ibid., 3 April 1883.

<sup>66</sup> Elston 'Run by Women (mainly) for Women'. p.74.

<sup>67</sup> Sanchez, *Sympathy and Science*, p.196.

<sup>68</sup> R. Morantz-Sanchez, *Conduct Unbecoming a Woman. Medicine on Trial in Turn-of-the-Century Brooklyn* (New York and Oxford, 1999), p.77.

<sup>69</sup> Ibid.



resembled Tait's in many ways. As a surgeon, she was 'bold, radical and innovative', and quick to criticise her more conservative colleagues.<sup>70</sup> As may be expected, in the debate regarding the controversial procedure of ovariectomy (discussed in Chapter Three), Dixon Jones made a point of distinguishing between Tait's operation, which she favoured and Battey's, the indications of which she claimed to be too loosely defined. Similarly, Garrett Anderson's practice was very similar to mainstream therapeutics; she undertook a variety of surgical procedures, including two cases of ovariectomy, almost certainly the first cases performed by a female surgeon.<sup>71</sup> Young and enthusiastic, Elizabeth quickly adopted the emerging practice of antiseptic technique and described Lister's theories on antisepsis as 'one of the greatest glories of science in her time'.<sup>72</sup> She was also willing to ask for help from those eminent surgeons who had supported her in her early career although she refused to employ male medical staff at the hospital. 'No men or no hospital' was her reply when her colleague Frances Hogan, more cautious in her approach than Garrett Anderson, proposed that a male surgeon be called for abdominal surgery.<sup>73</sup>

Relationships between the female medical staff and their male colleagues appear to have been more cordial in Birmingham, doubtless due to the excellent reputation established by Louisa Atkins. Speaking at the Annual Meeting (1873), Joseph Chamberlain congratulated Atkins on the favourable reports on her work that had been read, the Institution on acquiring the services of 'so able an officer' and especially, 'those members of the medical

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<sup>70</sup> Ibid., p.79.

<sup>71</sup> Manton, *Elizabeth Garrett Anderson*, pp. 228-29.

<sup>72</sup> Ibid.

<sup>73</sup> Ibid., p.229.



profession who had risen above prejudice by receiving a lady as a colleague'.<sup>74</sup> In truth, Atkins quickly gained the respect of the medical staff; some nine months after her appointment the Medical Board noted that Atkins had proved herself to be 'thoroughly competent' had shown 'much ability and zeal', and had given 'great satisfaction'.<sup>75</sup> The following year, the medical staff wished to 'express their unanimous approval of the excellent manner in which the RMO has carried out her duties' and 'bear testimony to the cordiality and confidence that has existed between her and them'.<sup>76</sup> Perhaps more telling is Lawson Tait's practice of entrusting his patients to the care of Atkins when he went on annual leave.<sup>77</sup>

Nonetheless, it is evident that, as with most medical appointments to voluntary hospitals, Atkins regarded the position as a stepping stone in her career. In the spring of 1874, some seventeen months after her appointment, the Management Committee reported that they had received a letter from Louisa Atkins, giving notice of her intended resignation as she was 'desirous of entering private practice'.<sup>78</sup> It is clear that neither the Governors nor the medical staff were anxious to lose her services. Thus, a compromise was reached whereby Atkins was offered the post as non-resident, to allow her to develop her private practice.<sup>79</sup> Atkins agreed to stay a further year and finally resigned in 1875 to rejoin Garrett Anderson at her New Hospital for Women in London.<sup>80</sup> Her replacement, Edith Pechey whose appointment has been

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<sup>74</sup> BCA, BMHW, 1/10/1, Annual Report, 1873.

<sup>75</sup> Ibid., HC/WH 1/5/1, Medical Board, March 1873.

<sup>76</sup> Ibid., March 1874.

<sup>77</sup> Ibid., 29 August 1874.

<sup>78</sup> Ibid., HC/WH 1/1/1, Board of Governors, 3 March 1874.

<sup>79</sup> Ibid., 6 May 1874.

<sup>80</sup> Manton, *Elizabeth Garrett Anderson*, p.224.

described above, remained at the hospital only twelve months.<sup>81</sup> The next house surgeon, Annie Barker, appointed on the same basis as Pechey, remained at the hospital for two years during which time she was granted leave to study in Paris.<sup>82</sup> In their Annual Report (1877), the Medical Board were pleased to report that Miss Barker had 'obtained the degree of M.D. of Paris, and also the License of the Irish College of Physicians [which] allowed her to be placed on the Medical Register'.<sup>83</sup> Thus, the governing body was put in the recurring untenable position of appointing doctors who were not technically qualified. As the Managing Committee noted in their Annual Report (1875), this put a great responsibility on those who wished to secure the services of a lady on its medical staff. To such a Committee, it was not only desirable that women who were competent should receive legal recognition but their right. They called on all those interested in Hospitals for Women to support efforts 'in Birmingham and elsewhere to obtain for women who have properly qualified themselves the right of registration'.<sup>84</sup>

Notwithstanding the difficulties they faced in recruiting female medical staff, few doubted the wisdom of doing so. In 1873, Dr Heslop, Consulting Physician, had said that it was an admirable thing in Birmingham when Dr Louisa Atkins had been appointed. 'They not only started an original principle, but they manifested a desire to get rid of foolish prejudices, and that a fair field and no favour should be given to a competent lady candidate, who came forward to seek the office.'<sup>85</sup> He continued, 'speaking on the part of many of the ablest and best known of his calling in Birmingham, he could say

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<sup>81</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, 4 April 1876.

<sup>82</sup> Ibid., 14 November 1876.

<sup>83</sup> Ibid., HC/WH 1/10/1, Annual Report, 1877.

<sup>84</sup> Ibid., Annual Report, 1875.

that the accession of that lady to the number of practitioners of surgery would be welcomed'.<sup>86</sup> As we have seen, the hospital remained committed to its original principle and actively sought lady candidates for office. In part, this was an expression of their commitment to the furtherance of women's education but it is evident that the contribution of female practitioners was valued. Commenting on the increased efficiency in the out-patient department, the Committee of Management acknowledged that this was 'made possible by the important share that Miss Pechey has taken in the examination and treatment of the out-patients'.<sup>87</sup> This was an obvious value to the Institution but equally useful for the junior doctors. During the year Pechey was in post a total of 2,123 new cases were seen in clinic, a further 266 cases being rejected after examination as unsuitable.<sup>88</sup> This allowed Pechey, and others, to acquire a thorough grounding in the diseases of women. Aside from the wide range of gynaecological conditions encountered, diseases of the urinary system, the bowel, pelvic and abdominal disorders and diseases of the breast were seen. Disorders connected with early pregnancy and parturition also came within their remit.<sup>89</sup> Further, despite their claim to reject those whose ailments did not come within the scope of the Institution, there were a number of cases that would have been more appropriately treated in a general hospital. These included women suffering from chronic bronchitis, phthisis, tape worm and obesity.<sup>90</sup> This valuable

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<sup>85</sup> Ibid., Annual Report, 1873.

<sup>86</sup> Ibid.

<sup>87</sup> Ibid., Annual Report, 1875.

<sup>88</sup> Ibid.

<sup>89</sup> Ibid.

<sup>90</sup> Ibid.

experience more than compensated for Pechey's lack of technical qualifications and proved to be a useful stepping-stone in her future career.

It is apparent that the 'special qualities' associated with women doctors was equally valued. In the Annual Report (1881) it was acknowledged that 'no one who has seen the working of this Institution can doubt the propriety of their assistance in respect to the peculiar ailments of their own sex'.<sup>91</sup> Nonetheless, the Governors were not content to employ lady doctors merely as an advocate on behalf of her sex. As we have seen, they were determined that in a women's hospital there should be at least one senior female physician. In the same Report they proudly announced 'This is the only hospital in the country whose Honorary Acting Staff includes ladies as well as gentlemen'.<sup>92</sup> The emphasis placed on this statement (present in the original) rather suggests that, notwithstanding their nonconformist democratic principles regarding the employment of women, the governing body was clearly aware of the potential advantages of this policy. Doubtless, the presence of senior female staff appealed to patients; it would also be met with approval among a wider audience, thereby attracting new subscribers. Support for lady doctors among the lay public had long been greater than that within the profession. Following the threatened resignation of the medical staff in Bristol, a resolution was put to the subscribers that 'medical and surgical appointments to the hospital be henceforth open to lady candidates'; the resolution was carried by seventy-two votes to seventeen.<sup>93</sup>

The campaign to gain entry for women into medicine had the unplanned but fortuitous consequence of furthering the cause of women seeking a more

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<sup>91</sup> Ibid., HC/WH 1/10/2, Annual Report, 1881.



modest professional qualification.<sup>94</sup> As Ellen Jordan has noted, those seeking a career in medicine usually came from comfortable families who could afford to support them throughout their period of study. Many more women needed to earn their own living and hoped to do so 'in an occupation less crowded than teaching or dressmaking'.<sup>95</sup> Dispensing offered one such opportunity. Elizabeth Garrett has been credited with establishing dispensing as a career for women.<sup>96</sup> The Society for Promoting the Employment of Women (SPEW), noted in their 1869 Report that 'one young woman, who had received a regular course of instruction at St Mary's Dispensary ... has been appointed dispenser to that institution'.<sup>97</sup> Other appointments followed and the SPEW confidently predicted that 'both analytical chemistry and dispensing might be advantageously studied by women, and might afford them suitable and remunerative employment'.<sup>98</sup> Jonathan Reinartz has argued that the decision to appoint a female dispenser was often influenced by financial considerations, suggesting that women were paid less than men.<sup>99</sup> I would suggest that such a position is an over-simplification. Although the 'Babbage' principle of wide pay differentials between qualified dispensers and untrained assistants was usual, the salaries, and pay and conditions of service for women, was the same as those offered to men.<sup>100</sup> As will be shown further

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<sup>92</sup> Ibid.

<sup>93</sup> *Englishwoman's Review*, new series, 4 (1873), p. 227.

<sup>94</sup> E. Jordan, 'Suitable and Remunerative Employment: The Feminization of Hospital Dispensing in Late Nineteenth-Century England', *Social History of Medicine*, 15 (2002), p.455.

<sup>95</sup> Ibid., p.436.

<sup>96</sup> Ibid., pp.436-37.

<sup>97</sup> Society for Promoting the Employment of Women, Annual Reports 1859-1958. Cited *ibid*, p.436.

<sup>98</sup> Ibid.

<sup>99</sup> J. Reinartz, 'Healthcare and the Second City. The Development of the Birmingham Teaching Hospitals in the Nineteenth Century', *Birmingham Historian*, 26 (2004), p.23.

<sup>100</sup> Jordan, 'Suitable and Remunerative Employment', pp. 430, 436.

below, the gender differential between pay scales in the profession arose towards the end of the nineteenth century and was largely due to the adoption by women of a lesser qualification. Moreover, such arguments fail to examine the role that women played in developing the dispensary service in hospitals and public institutions in the late nineteenth century. The out-patient department of nineteenth-century hospitals were invariably busy, especially those in specialist hospitals. Patients soon realised that doctors with a particular interest in their type of disease were readily available in the clinics of such hospitals, which ensured their popularity with the public.<sup>101</sup> The Women's Hospital was no exception; in the first five months following the opening of the Institution, 596 new cases were seen, requiring a total of 2,943 clinic attendances. With only eight beds available for surgery, of necessity, in the early years most women were treated by methods other than operation.<sup>102</sup> Thereby, drugs and medical appliances, such as pessaries, to relieve chronic gynaecological conditions, constituted an important part of the medical care of patients.

The legal responsibility for the administration of drugs in small institutions lay with the medical staff or part-time dispensing chemist. The day-to-day dispensing and management of the department fell to the dispensary assistant, for whom no formal qualifications were required. Nonetheless, the implications of poor practice on patient care and the huge costs of the medicines involved required the efficient management of the dispensary service. Herein lay the problem; in their first Annual Report (1872) the Governors expressed their lack of confidence in the current arrangements:

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<sup>101</sup> L. Granshaw, *St Mark's Hospital, London. A Social History of a Specialist Hospital*

'The manner in which the duties of this office have been discharged by the gentlemen, who at various times accepted the post, and the short time which they remained had been a source of considerable anxiety to your committee.'<sup>103</sup> Hence, their decision to employ a lady dispenser, Miss Harding in 1872.<sup>104</sup> As noted above, Garrett Anderson began employing women in hospital dispensing in 1868, but throughout the 1870s there was still a strong prejudice against them.<sup>105</sup> Thus, opportunities for employment seldom arose and the decision to engage Harding was considered by some to be controversial, but was soon to prove amply justified. After a period of training under the auspices of Mr Lucas, a qualified chemist and a member of the Pharmaceutical Society, the medical staff reported that 'the dispensing has been much more satisfactorily conducted since Miss Harding's appointment than under any previous arrangement'.<sup>106</sup> The respect that Harding earned from the medical staff and the Governors owed much to her drive and ambition. Few women at that time sought formal dispensing qualifications, although the SPEW encouraged them to do so.

By 1872 such possibilities were increasing, although there remained fierce resistance to allowing women full membership of the Pharmaceutical Society. Members of the Council were, however, responsive to proposals that the lectures and examinations of the Society should be open to women.<sup>107</sup> It would appear that Harding lost little time; she commenced her studies and

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(London, 1985), p.79.

<sup>102</sup> BCA, BMHW, HC/WH 1/5/1, Medical Board, March 1872.

<sup>103</sup> Ibid., HC/WH 1/10/1, Annual Report, March 1872.

<sup>104</sup> Ibid.

<sup>105</sup> Society for Promoting the Employment of Women, Annual Reports, 1859-1958. Cited Jordan, 'Suitable and Remunerative Employment', p.436.

<sup>106</sup> BCA, BMHW, HC/WH 1/10/1, Annual Report, March 1873.

<sup>107</sup> Jordan, 'Suitable and Remunerative Employment', p. 437.



subsequently passed the Preliminary Examination of that Society, being one of only twenty-one candidates to get a 'First'.<sup>108</sup> Following her own success, Harding undertook the training of another female pupil, a practice that was maintained throughout our period. Harding was to remain at the hospital for five years but her successor, Miss Percival, found the work too taxing and resigned after less than twelve months.<sup>109</sup> The next appointee, Elizabeth Swain, was more successful and in 1880, passed the Preliminary Examination of the Pharmaceutical Society.<sup>110</sup> Neither Harding nor Swain progressed to the more advanced Minor Examination; nonetheless, even obtaining the lesser qualification was the exception rather than the rule. One reason may have been the difficulty in securing a position where they could obtain the necessary three years experience. Additionally, the costs of lecture fees and laboratory training could be quite significant and the academic rigour of the course was demanding.<sup>111</sup> Elizabeth Swain, for example, clearly struggled and needed five weeks leave of absence to prepare for her examination, due to her 'backwardness in Latin'.<sup>112</sup>

The study leave was granted but even this limited support for women to pursue a career in pharmacy was unusual. Florence Brittain, who had trained twelve pupils over a period of eight years, complained that only a small proportion of these young women proceeded to take any formal examination. This was 'almost entirely due, either to the heavy handicapping of many by the non-recognition the part of parents and guardians of the unavoidable outlay of money and time necessary for efficient technical education – a

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<sup>108</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, 4 August 1874.

<sup>109</sup> Ibid., HC/WH 1/3/1, House Committee, 5 June 1877.

<sup>110</sup> Ibid., HC/WH 1/1/1, Board of Governors, 2 March 1880.

<sup>111</sup> Jordan, 'Suitable and Remunerative Employment', pp.445-46.



handicapping which does not effect a woman devoting herself to the sister profession of medicine'.<sup>113</sup> Perhaps recognizing the difficulties associated with three years intensive study, Britain promoted the Apothecaries Assistant's Certificate as 'an agreeable break in the three years practical work necessary to become qualified'.<sup>114</sup> The Certificate had several advantages; the theoretical input was less demanding, the associated fees less and only a six month period of experience was required. Overall, it provided a 'convenient stepping stone (to the examinations) of the Pharmaceutical Society' for those who wished to proceed to the higher qualification.<sup>115</sup> Although it was claimed that opportunities for women to train in the profession were better in Britain than anywhere outside America, few women took advantage of this.<sup>116</sup> Apart from those on the 1868 British register for chemists and druggists, by 1892 only a further eight women had registered as pharmaceutical chemists and eleven had qualified as chemists and druggists.<sup>117</sup> Many women, by choice or of necessity, did not progress beyond the Assistant's Certificate. Conversely, the number of male applicants declined from this period, with men more often opting for the higher qualifications needed to progress their career. Thus, by the end of the nineteenth century female dispensers accounted for around 75 per cent of candidates for the Assistant's examination.<sup>118</sup>

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<sup>112</sup> BCA., BMHW, HC/WH 1/1/1, Board of Governors, 2 March 1880, 6 July 1880.

<sup>113</sup> 'Lady Pharmacists', *Chemist and Druggist*, p.144

<sup>114</sup> *Ibid.*, p.145.

<sup>115</sup> *Ibid.*, pp.144-45.

<sup>116</sup> *Ibid.*, p.143.

<sup>117</sup> *Ibid.*,

<sup>118</sup> Court of Examiners: Candidates Declaration Books, 1885-1900 (Guildhall Library: Ms 8240 Vol. 9). Cited Jordan, 'Suitable and Remunerative Employment', p.448.

The influx of women into the profession was partly due to the growth in demand. The introduction of chemist departments in major stores and the rapid growth of retail chains, like Jesse Boot's 'cash chemists' meant that opportunities for dispensing assistants increased significantly.<sup>119</sup> The confirmation by the Local Government Board in 1895 that the Apothecaries Assistants' Certificate was deemed acceptable under the 1868 Pharmacy Act for a dispenser in a public institution further enhanced its legitimacy.<sup>120</sup> Salaries rose accordingly; for example, at St Olave's, Bermondsey the salary paid to the chief dispenser in 1876 was £30, with a marginal increase to £40 per annum by 1882. Between 1882 and 1894, salaries rose more rapidly, first to £80, then £90 per annum. By 1902, the dispenser earned an annual salary of £120.<sup>121</sup> Nonetheless, holders of the Apothecaries Assistants Certificate, the majority of whom were women, remained in the 'unpromotable' section of the profession. This did not please those within the women's movement who had anticipated that entry to the examinations of the Pharmaceutical Society, would promote greater equality within the profession between men and women.<sup>122</sup>

It is worth noting that a number of women did achieve this ambition. Although some reported 'occasional trying experiences', most women who responded to a survey by the *Chemist and Druggist* (1892) promoted pharmacy as 'a very suitable profession for women'.<sup>123</sup> Few women had experienced difficulty in obtaining positions, while some like Miss Stammwitz and Miss Minshull, who had been among the first to take the Pharmaceutical

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<sup>119</sup> Ibid., p.451.

<sup>120</sup> Ibid., p.452.

<sup>121</sup> London Metropolitan Archives, B/BG/660/1. Cited *ibid.*, p.452.

<sup>122</sup> Ibid., p.455.

Society's examinations, reported that they had been offered a variety of suitable posts.<sup>124</sup> Minshull had remained within the hospital environment and was firmly of the opinion that 'certainly in women's and children's hospitals, a lady dispenser is the right woman in the right place'.<sup>125</sup> Stammwitz, and a number of other correspondents, had set up in business independently. Held to be less exhausting than hospital work, private practice naturally had some appeal. The major difficulty was the prejudice against trade. Socially, chemists were on par with other tradesmen and it was observed that as long as this absurd prejudice continued, the superior social status of the medical profession would have a greater attraction for women.<sup>126</sup> Several other women alluded to the relationship between medicine and pharmacy; some had opted for the latter only because of the difficulties in obtaining medical training when they commenced their studies.<sup>127</sup> This would suggest that the social background of lady dispensers was wider than has sometimes been portrayed. Some, perhaps the minority, were clearly as intellectually gifted as lady doctors and able to cope with the rigours of a scientific education. Such women subsequently pursued a career as pharmaceutical chemists. The majority of women, however, found the Apothecaries Certificate admirably suited their purpose and saw little advantage in undertaking any additional training.

Margaret Buchanan (who qualified as a pharmacist in 1887) was dismissive of those who had taken this comparatively easy examination that required the dispenser to work under the supervision of a doctor or as an

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<sup>123</sup> 'Lady Pharmacists', *Chemist and Druggist*, p.144.

<sup>124</sup> *Ibid.*, pp.144-45.

<sup>125</sup> *Ibid.*, p.145

<sup>126</sup> *Ibid.*, p.144.

assistant in a hospital dispensary'.<sup>128</sup> The SPEW were generally more ambivalent and acknowledged that three years training represented a huge investment for women who needed to earn their own living, often for a relatively short period between school and marriage. They recognized that such women were less ambitious than their male counterparts and actively sought places where girls might be apprenticed for the diploma from the Apothecaries Hall. By the end of the century this strategy had met with some success. As the Society noted in their Annual Report (1899) 'the demand for women dispensers, though still small is on the increase'.<sup>129</sup> Understandably, hospitals welcomed the new grade of employees; they could not command the salary of a qualified chemist but the diploma ensured that they were better educated than the dispensary porters previously employed. The entry of women into the profession, often prepared to stay in a position between three to five years, also resulted in a greater continuity of staff in the dispensary. Overall the new generation of female dispensers proved to be far more reliable and competent than the untrained dispensary assistants they displaced.

It would seem that it was these qualities that informed the Governor's decision to appoint a lady dispenser to the Women's Hospital in 1872, rather than pecuniary concerns. Salaries at the hospital during the 1880s and 1890s appear comparable to those noted above in institutions of similar size.<sup>130</sup> The salaries of the dispensing staff are also commensurable with those of other

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<sup>127</sup> Ibid.

<sup>128</sup> M. Buchanan, 'Pharmacy', in Spencer (ed.), *The Fingerpost*. Cited Jordan, 'Suitable and Remunerative Employment', p.455.

<sup>129</sup> Society for Promoting the Employment of Women, Annual Reports 1859-1958, 1899, p.9. Cited *ibid.*, p.454.

<sup>130</sup> See *ibid.*, pp.449 and 452, for details of salaries between the 1870 -1890s.



professional staff employed at the hospital. On her appointment as RMO Atkins received a salary of £50 per annum, plus board.<sup>131</sup> In the same year, Harding commenced on a salary of £20 per annum, the same as her predecessor, Mr Davies and this was increased to £30 per annum, before she passed her Preliminary Examination.<sup>132</sup> After passing her examination in 1880 Swain received £45 per annum.<sup>133</sup> The salary of the 'sister in charge' of the hospital at that time was around £50 per annum.<sup>134</sup> Opportunities for advancement were also improving. The appointment of Harding had marked the beginning of a trend in Birmingham. As had been the experience of women doctors, female dispensers found employment at the Children's Hospital and other hospitals in the town. Of particular interest, in the context of this thesis, is the employment of women dispensers at the Provident Dispensaries, discussed in Chapter One. Blanche Thompson, Dispenser at the out-patient department of the Women's Hospital, attributes this to Lawson Tait, whom she describes as 'an advocate for women dispensers'.<sup>135</sup> She explained how Tait would 'put an advertisement in the paper for a married couple - the man to act as secretary and the woman as dispenser (and) paid the expenses of the woman to train in a chemist shop'.<sup>136</sup> Tait clearly maintained his interest in the education of women. Thompson reports that 'It was through the influence of Mr Lawson Tait that the authorities of Mason's

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<sup>131</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, 4 June 1872.

<sup>132</sup> Ibid., 2 December 1873.

<sup>133</sup> Ibid., 6 July 1880.

<sup>134</sup> Ibid., 6 June 1882.

<sup>135</sup> B. Thompson, 'Some Reminiscences of Lawson Tait', *Birmingham Medical Review*, 4 (Birmingham, 1931), p.142.

<sup>136</sup> Ibid.

College allowed me to join the class in Materia Medica – *then* all men students (1885)<sup>137</sup>

In the larger public institutions career progression for female dispensers was possible; the aforementioned Florence Brittain, described herself as 'Head Dispenser' at a hospital in Birmingham.<sup>138</sup> Opportunities were more limited at the Women's Hospital although the status of the Dispenser was enhanced as additional responsibilities were added to the post. Blanche Thompson, appointed in 1883 later acquired the rather grand title of Registrar and Dispenser.<sup>139</sup> In practice, 'registrar' described the person who registered the patients but it seems that her role was much wider. Reference is made to Miss Thompson being asked to report back to the Management Committee any problems relating to the smooth running of the clinics, including poor time-keeping by the medical staff.<sup>140</sup> Thus, effectively Thompson managed the out-patient department, previously the responsibility of nurse in charge of the clinics. This arrangement resulted in one of the busiest departments in the hospital being largely in the hands of non-medical personnel, a situation that was facilitated by the agreement of the Governors to install a telephone, an instrument then still relatively unknown.<sup>141</sup> Evidently, the medical staff were satisfied with this arrangement. As was their practice with lady doctors, they invariably paid tribute in their Annual Report to the valuable and able work of their female dispensers.<sup>142</sup>

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<sup>137</sup> Ibid. Tait was elected a Trustee of Mason College and Member of the Council in 1886 and appointed Bailiff of the College in 1890. With the transfer of the Medical Faculty of Queen's College to Mason College in 1891, Tait was appointed Professor of Gynaecology.

<sup>138</sup> 'Lady Pharmacists', *Chemist and Druggist*, p.144.

<sup>139</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, 1 October 1888.

<sup>140</sup> Ibid., 8 January 1889.

<sup>141</sup> Ibid., 5 August 1879.

<sup>142</sup> Ibid., HC/WH 1/10/4, Annual Report, 1901.

As Arthur Chamberlain observed in 1901, the decision to employ female dispensers at the hospital had proved 'eminently satisfactory at all times' from the hospital's point of view.<sup>143</sup> He hoped that it had also been satisfactory to the ladies and by the number of years that many remained at the Institution it would seem that it was. Certainly, Thompson had warm memories of the institution, which she associates largely with her work for Lawson Tait. Many years after her retirement, she recalled 'There was something so wonderful about Mr Lawson Tait, it was his genius, his personality, and everyone felt alert on those out-patient days.'<sup>144</sup> Possibly, this suggests a degree of 'hero-worship' but understandably so. Thompson describes the 'great number of patients who came from all over the world to see Mr Tait and even doctors from over the seas came to see the great man work'.<sup>145</sup> From Thompson's account of Tait's manner with staff and patients, it would seem that there was a humbler side to his nature; she remembered that 'however busy he was he would always listen to a tale of woe and be ready to advise and help'.<sup>146</sup> It would appear that women generally found the occupation congenial, which is perhaps unsurprising. As noted above, conditions of employment for female dispensers nationally were the same as those offered to men, although the salary was expected to cover all living expenses as the post was non-resident. Consequently, unlike other occupations deemed suitable for middle-class women, such as governesses, or hospital nursing, there was no supervision of leisure time.<sup>147</sup> Therefore, notwithstanding increasing pressure

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<sup>143</sup> Ibid.

<sup>144</sup> Thompson, 'Some Reminiscences of Lawson Tait', p.142.

<sup>145</sup> Ibid.

<sup>146</sup> Ibid.

<sup>147</sup> Jordan, 'Suitable and Remunerative Employment', pp. 435-36.

within the profession to raise the standard of qualifications, the certificate remained popular with women throughout the First World War.<sup>148</sup>

Another reason that the hospital retained female staff may have been that they found the environment supportive. The number of women employed at the hospital possibly contributed to this. As has been shown, from the 1890s, there were at least three female medical staff in post, a female dispenser plus twelve lady Governors who played a very active role in the day-to-day running of the Institution. Aside from the benefits of social companionship, it is reasonable to expect that senior female colleagues would have encouraged newly qualified women in their future career. Mary Roth Walsh has suggested that it is impossible to exaggerate the importance of feminist friendships, noting particularly the help Elizabeth Blackwell gave Marie Zakrzewska in overcoming the many practical obstacles that faced female physicians setting up in practice.<sup>149</sup> By the later decades of the nineteenth century, a female medical subculture had emerged in America; this provided the kind of nurturing and support that was particularly useful to the first generations of women physicians.<sup>150</sup> Morantz-Sanchez has suggested that even the surgeon, Mary Dixon Jones derived satisfaction from her early links to feminist networks, although later in her career she abandoned these in favour of strategies of self-advancement adopted by men.<sup>151</sup> Feminist professionalism also paved the way for the establishment of women's medical societies in

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<sup>148</sup> Ibid., p.455.

<sup>149</sup> M. Roth Walsh, *'Doctors Wanted: No Women Need Apply'. Sexual Barriers in the Medical Profession, 1835-1975* (New Haven and London, 1977), pp.80-82.

<sup>150</sup> Morantz-Sanchez, *Conduct Unbecoming a Woman*, p.64.

<sup>151</sup> Ibid.



America which, like those for their male colleagues, offered professional assistance to their members and acted as 'arbiters of professional conduct'.<sup>152</sup> Similarly, an Association of Registered Medical Women was formed in Britain in 1879, with the aim to promote social exchange between women doctors and provide a forum for disseminating current medical practice. Those present at the first formal meeting of the Association on 4 May 1880 were: Elizabeth Garrett Anderson; Sophia Jex Blake; Louisa Atkins; Annie Clarke; Eliza McDonagh; Elizabeth Dunbar; Annie Barker and Matilda Chaplin Ayrton.<sup>153</sup> In theory, their male colleagues were welcomed and invited to lecture at the Association's meetings but in practice the monthly lecture, more often dealing with the diseases of women or children, was usually given by a member of the Association. On this occasion a paper was read by Annie Clarke, describing a series of 50 cases of hip joint disease treated by Thomas Splint at the Children's Hospital, Birmingham. At the first annual meeting on 3 May 1881, Edith Peachy posed some questions on the treatment of puerperal fever and what remedies could be relied upon in the treatment of septicaemia.<sup>154</sup> By the mid-1890s meetings were held on a monthly basis; they followed the same format with the main part of the evening devoted to a clinical paper. Their interest extended beyond a case study approach however; for example, when they discussed dilation of the cervix they decided to collect statistics and general information relating to the whole subject, including the context in which this procedure was necessary, its dangers and the best methods of performing it. Whilst many of these women were committed feminists there is

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<sup>152</sup> E. S. More, *Restoring the Balance. Women Physicians and the Profession of Medicine, 1850-1995* (Cambridge, Mass. and London, 1999), pp.44-45.

<sup>153</sup> Wellcome Library, MA/MWF P.1, Association of Medical Women, Minute Book, Volume 1, May 1879 - July 19, 1907,

no evidence to suggest that their practice differed greatly from their male colleagues. For example, Mrs Keith gave a paper on the prolapse of the vagina and hypertrophical cervix in pregnant women and Mrs Sharlieb read a paper on the analysis of 100 cases of abdominal sections she had recently performed.<sup>155</sup>

They were also keen to keep abreast of scientific developments and agreed to form a Pathological Society as a branch of the Association. It is possible that this was due to the influence of Garrett Anderson, whose practice was very similar to mainstream therapeutics. This may not have been the position taken by all women as support for the Association was dwindling. In July 1895 the monthly meeting had to be cancelled due to poor attendance. A notable absence was Jex-Blake who did not attend meetings of the Association after the first year and by 1891 the attendance of doctors from the Women's Hospital, Birmingham had fallen off. Edith Peachy kept in contact with the Association and attended meetings when she was in England. On one such occasion Mary Sturge also attended the meeting as a visitor, subsequently joining the Association in May 1892.<sup>156</sup> By the end of 1890s the number of women joining the Association was growing, with an average attendance of 25 women at the monthly meetings. Nonetheless, this represented only a very small portion of the number of qualified women doctors in the UK, which stood at 750 in 1906.<sup>157</sup> It is evident that there were widely different opinions on some issues, for example, as to whether they

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<sup>154</sup> Ibid., 4 May 1880, 3 May 1881.

<sup>155</sup> Ibid., 3 May 1892, 3 March 1896.

<sup>156</sup> Ibid., 5 April 1892, 3 May 1892, July 1895.

<sup>157</sup> Witz, *Professions and Patriarchy*, p.100.

should have a register for medical women in need of work.<sup>158</sup> A further explanation may be a clash of personalities; there had long been a difference of opinion between Garrett Anderson and Jex-Blake and this had the unfortunate consequence of creating opposing factions within this small group of medical women.<sup>159</sup> Notwithstanding some differences of opinion, the Association did provide a useful forum for discussion and peer support, particularly for newly qualified women practitioners. It is likely that those who found the Association most useful were those who, like Garrett Anderson, believed in working for the women's cause through the medium of mainstream medicine.<sup>160</sup> This philosophy reflected the approach of the doctors at the Women's Hospital; Mary Sturge was to be one of the Association's strongest supporters, as was another Birmingham doctor, who was perhaps the most successful in raising the profile of women doctors in the national arena, Hilda Shufflebothan, later Professor Dame Hilda Lloyd-Rose.

Less formal networks also existed amongst medical women. Atkins lost little time in using her position to provide clinical experience for others, requesting in March 1873 that she might be allowed to take a lady pupil.<sup>161</sup> This became established practice and women doctors at the hospital invariably nominated their replacements, even for short absences. Such practical assistance was particularly helpful as the career patterns of women physicians tended to be concentrated in specialized fields of medicine, such as the care of women and children. This phenomenon was common in North

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<sup>158</sup> Wellcome Library, MA/MWF P.1. Association of Medical Women, Minute Book, Volume 1. Most women could not see the point of having a register whilst others thought it should not be in connection with the Association.

<sup>159</sup> This is shown by opposing nominations to the post of Honorary Secretary to the Executive Council of the London School of Medicine. See Roberts, *Jex-Blake*, pp.158-59.

<sup>160</sup> *Ibid.*, p.60.



America and Europe. Of the thirteen women who qualified as doctors in the Netherlands, between 1878 and 1900, ten went on to work 'in areas connected in some way to the care of women or children'.<sup>162</sup> The limited choice available to lady physicians highlights the value of women obtaining wide experience of clinical practice in their early career, particularly in relation to the growing significance of women's hospitals from the late 1880s. Such experience was not always available in women-run institutions, which were often small and ill-equipped. As will be discussed in Chapter Four, the treatment in Jex-Blake's Edinburgh Hospital for Women and Children was largely based on the regulation of bodily physiology, as advocated by Thomas Coulston.<sup>163</sup> Surgical procedures were rare; Elaine Thomson records only sixteen minor operations in Edinburgh between 1886-1899, only one major operation was performed, for the removal of a malignant growth of the uterus.<sup>164</sup> The wide range of conditions seen at the Women's Hospital in Birmingham has been described above. In addition to the experience gained in the out-patient department, the junior medical staff were assistant surgeons and thus gained first-hand knowledge of operative gynaecology, plus a number of general abdominal procedures.

The practical experience thus gained appears to have served the young women doctors well. As noted above, following her resignation, Louisa Atkins returned to join Garret Anderson in London, reportedly allowing Garret

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<sup>161</sup> BCA, BMHW, HC/WH 1/5/1, Medical Board, 29 March 1873.

<sup>162</sup> H. Marland, 'A Woman's Touch: Women Doctors and the Development of Health Services for Women and Children in the Netherlands 1879-c.1925', in H. Binneveld and R. Dekker (eds), *Curing and Insuring. Essays on Illness in Past Times: the Netherlands, Belgium, England and Italy, 16<sup>th</sup>-20<sup>th</sup> Centuries* (Hilversum, 1993), p.114.

<sup>163</sup> Thomson, 'Women in Medicine', p.165.

<sup>164</sup> *Ibid.*, p.143.



Anderson to take her first holiday in three years.<sup>165</sup> Atkins went on to establish a successful career as a physician and lecturer but perhaps her successor, Edith Pechey, was to become the most distinguished of the early female doctors. Having first acquired her MD in Bern, Pechey joined Annie Clarke in Dublin and passed the examinations that qualified her as a Licentiate of King and Queens's College of Physicians in Ireland. Finally eligible for admission to the Medical Register, Pechey practised in Leeds for three years where she became involved with women's education, lecturing to women's groups on a variety of subjects related to women's health and well-being.<sup>166</sup> Pechey was also active in women's rights movements. Padma Anagol notes that she 'helped to set up the Medical Women's Federation in England (and) was elected president of the federation in 1882'.<sup>167</sup> In 1883, as part of a Medical Women for India initiative, Pechey was engaged by the American businessman George T. Ketteridge, to establish a new medical department for the medical care of the women of India. Ketteridge was convinced that 'for success in India the women must be recognized as the equal of men in the medical care of their own sex'.<sup>168</sup> Financial support was given by a Parsee gentleman, Mr Pestonjee Cama, who offered to build a hospital on the condition that it was 'entirely in the charge of women doctors'.<sup>169</sup> Pechey has been judged a great success in India; within a year she had learned to speak and write Hindi and participated fully in the social and intellectual life of

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<sup>165</sup> Manton, *Elizabeth Garret Anderson*, p.244.

<sup>166</sup> P. Anagol, 'Phipson, (Mary) Edith Pechey (1845-1908), Physician and Women's Rights Activist', *Oxford Dictionary of National Biography* (Oxford, 2004-6), p.2.

<http://www.oxforddnb.com/view/printable/56460>. Accessed 8 October 2006.

<sup>167</sup> *Ibid.* The name of the Association of Medical Women was changed to the Women's Medical Federation in 1919.

<sup>168</sup> Moberley Bell, *Storming the Citadel* (London, 1953), p.117.

<sup>169</sup> *Ibid.*, p.118.

Bombay.<sup>170</sup> She is reputed to have had a good working relationship with her male colleagues in the local medical facilities but had one important difference of opinion with the Management Committee.<sup>171</sup> Pechey refused to charge a lesser fee than her male colleagues, as suggested by the Committee.

This was not because of the money involved, as the Medical Women for India Fund guaranteed her salary.<sup>172</sup> We have noted above the immense difficulties Pechey had experienced in establishing the right for women to practice medicine. Equality of treatment was an issue of the utmost importance to her but, as a compromise, she offered to treat any patient recommended by the committee free of charge. The Committee accepted this offer and did not again question the principle of equal pay.<sup>173</sup> Padma Anagol notes that throughout her time in India, 'Edith strove to improve the position and status of women in the medical profession'.<sup>174</sup> Certainly, she achieved personal recognition. Pechey was appointed Physician-in Charge to the Cama Hospital, when it opened in 1866.<sup>175</sup> The Institution was at that time unique in India and Edith acquired an influence that was widespread. She was invited to speak at public gatherings on the question of extending the opportunities for higher education for women. In 1891, Edith was elected to the Senate of the University of Bombay; two further prestigious appointments, to the Royal Asiatic Society and the Bombay branch of the National Indian Association, came the following year.<sup>176</sup> Pechey used her influence to promote social reform and was well known for her campaign against the

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<sup>170</sup> Anagol, 'Phipson, (Mary) Edith Pechey', p.2

<sup>171</sup> Moberley Bell, *Storming the Citadel*, p.118.

<sup>172</sup> Ibid.

<sup>173</sup> Ibid.

<sup>174</sup> Anagol, 'Phipson, (Mary) Edith Pechey', p.3.

<sup>175</sup> Bell, *Storming the Citadel*, pp.118-19.

institution of child marriage.<sup>177</sup> A pamphlet on this subject *Address to the Hindoos of Bombay on the subject of child marriage* (1890), was translated into 'a great many languages and widely circulated'.<sup>178</sup> Edith retired from her post at the Cama Hospital in 1894 but continued to take an active interest in social reform and public health issues. When bubonic plague struck Bombay in 1896, Pechey-Phipson (Edith married Herbert Phipson in 1889), publicly criticized the management of the plague operations. Her comments were noted by officials, who duly acted on her recommendations.<sup>179</sup> Owing to ill health (she struggled to cope with diabetes for a number of years), Edith and her husband left India in 1905. However, she maintained her interest in women's participation in the world of public affairs.<sup>180</sup> On her return to England she was active in the Leeds branch of the Women's Suffrage Association and represented them at the International Women's Suffrage Alliance in Copenhagen, in 1906. Her last public appearance was at the march organized by the National Union of Women's Suffrage Societies, in March 1907.<sup>181</sup> After her death, in 1908, her husband established a scholarship in her name at the London School of Medicine for Women, to be awarded to a medical student 'coming from India or going to work in India'.<sup>182</sup>

Edith's friend and former colleague, Annie Clarke never achieved the international reputation that Pechey acquired; however, she appears to have enjoyed a successful and satisfying career. As noted above, Clarke remained

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<sup>176</sup> Anagol, 'Phipson, (Mary) Edith Pechey', p.3.

<sup>177</sup> Ibid.

<sup>178</sup> Bell, *Storming the Citadel*, p.119.

<sup>179</sup> Anagol, 'Phipson, (Mary) Edith Pechey', p.3.

<sup>180</sup> Ibid.

<sup>181</sup> Ibid.

<sup>182</sup> Ibid. (Edith Pechey Phipson scholarship register, 1912-1948, Royal Free Hospital Archives Trust, London, no.603, Box 16). Cited *ibid.* For details of other medical women in India see, Bell, *Storming the Citadel* and C. Blake, *The Charge of the Parasols* (London, 1990).



at the Women's Hospital throughout her professional life but this does not indicate lack of career progression. By 1898 Clarke had attained the position of senior Honorary Medical Officer, an important mark of status for a female physician. Clarke retired from this post in 1913 but maintained her association with the Institution as Consulting Physician.<sup>183</sup> Mary Sturge served the hospital for thirty years, combining it with her successful private practice that included the children of the Cadbury family. As will be shown in Chapter Six, Mary's greatest contribution to the hospital was perhaps her work with women who were terminally ill. In her private life, Sturge was actively involved in women's organizations; the niece of the aforementioned Eliza, Mary Sturge also served on the committee of the suffrage society for many years.<sup>184</sup> Similarly, the women Governors were at the heart of the women's movement, notably in the fields of education and suffrage. Hannah Crosskey was a long serving officer of the Birmingham Women's Suffrage Society (BWSS). For a period during the 1880s, she acted as president, replacing her husband in this role. Hannah was also a member of Higher Education and Debating Societies and the Birmingham Branch of the Women's Liberal Federation.<sup>185</sup>

Among the most active in public work was Alice Beale who spent a great part of her life in social and public service, mainly connected with women and the poor. The fourth daughter of Timothy Kenrick, she inherited a tradition of public service that was strengthened by her marriage to Charles Beale in

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<sup>183</sup> W.B. Gough, 'The Birmingham and Midland Hospital for Women, 1871-1972', booklet produced by the hospital to celebrate the centenary of the hospital. Copy held at Birmingham Medical Institute.

<sup>184</sup> M.D. Green, *Images of Britain, Birmingham Women* (Stroud, Gloucestershire, 2000), p.53.

<sup>185</sup> H. Plant, "Ye Are All One in Christ Jesus": Aspects of Unitarism and Feminism in Birmingham, c. 1869-90', *Women's History Review*, 9 : 4 (London, 2000), p.726.



1868. Her interest in social work began shortly after her marriage; her mother-in-law had started the Birmingham District Nursing Society in 1870 and for some years Alice was the Honorary Treasurer. It was largely due to her efforts that the first home for nurses was built and the district nursing service greatly expanded. As we have seen, she was connected with the Women's Hospital from its foundation and was to be largely responsible for reorganizing the Lying-in Charity and the building of the Loveday Street Maternity Hospital, the foundation stone of which she laid in 1906. Beale was the first President of the Birmingham Settlement, a post she held for 25 years. She also worked with the Association for the Care and Protection of Young Girls and the Birmingham Union of Girls Clubs. On the foundation of the University she created the Women's Hostel and was an original member of the University Court of Governors.<sup>186</sup> In addition, Beale subscribed to the Ladies Education Society and the Higher Education Association, as did Caroline Kenrick who, at Henry Crosskey's invitation delivered a series of 'Lectures to Women on the Laws of Health'.<sup>187</sup> Mary Kenrick, Eliza Follet Osler, together with Arthur and Louisa Chamberlain and Joseph and Florence were all members of BWSS, and active in the Education Association Societies.<sup>188</sup>

The object of this chapter has been to explore the role women played in the provision of health care for women in Birmingham. As shown in Chapter

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<sup>186</sup> This biography has been compiled from the obituary notices published in the *Birmingham Post and Evening Dispatch*, 21 March 1940. Established in 1899, the Birmingham Settlement was entirely run by women and focused on women and children in one of the most deprived areas of the city, Green, *Images of Britain*, p.55.

<sup>187</sup> BCA, Church of the Messiah Home Mission Book, 1873-75, Church of the Messiah Calendar December 1873.

<sup>188</sup> Birmingham Central Library, Local Studies, Birmingham Women's Suffrage Society, Annual Report, 1868. Cited Plant, 'Aspects of Unitarianism', pp.728-29.

One, women enjoyed equality with men in the management of the Institution and the success of this working relationship is likely to have encouraged the Governors and medical staff to take the bold decision to appoint a woman doctor. As Chamberlain pointed out, this presented some risk to the Charity as they were in the recurring untenable position of appointing doctors who were not technically qualified. We have seen also that women doctors were equally at home in the male dominated medical environment. This raises some doubt about the validity of considering female physicians a discrete group, with shared values and principles of medical practice. Perhaps the different approaches to medicine are best illustrated by the two early pioneers, Elizabeth Garret Anderson and Sophia Jex-Blake. The most obvious difference was in clinical practice; Elizabeth believed in professional assimilation, whilst Sophia adopted a non-interventionist, holistic approach. It is evident that those who chose to work at the Women's Hospital were more in tune with Elizabeth's approach and flourished in the air of surgical optimism that permeated the hospital. It is to this aspect of hospital life that we turn to in the next chapter.

## Chapter 3

### *'A Man For His Time'*

#### *Lawson Tait and the Practice of Gynaecological Surgery.*

The purpose of this chapter is to explore clinical practice at the Women's Hospital during the important decades following its foundation, throughout which the Institution established its professional reputation in the field of women's health. Central to the history of the hospital during these early years is the figure of Lawson Tait, whose innovative practice did much to establish the hospital's international recognition. In the previous chapter, we looked briefly at Tait's support for women in medicine. A more detailed analysis of his career is offered below. As his biographers have noted, difficulties arising from Tait's professional prejudices and quarrelsome nature frequently brought him into conflict with his peers.<sup>1</sup> However, this able and energetic man flourished in the forward-thinking, radical environment of late Victorian Birmingham. Originality of thought was welcome in this city and the Women's Hospital provided the ideal setting for Tait to progress his speciality. As mentioned in the introduction to this thesis, the management of gynaecological disease underwent a fundamental shift in the nineteenth century. Innovations in surgery were central to these developments and, as the century progressed, surgery was the pivot around which gynaecology revolved.<sup>2</sup> In the following paragraphs, we examine the rise of surgical gynaecology and the increasing role it played in the treatment of gynaecological conditions. Attention is given to

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<sup>1</sup> For Tait's intransigent attitude to Listerism and vivisection, see, J.A. Shepherd, *Lawson Tait. The Rebellious Surgeon (1845-1899)* (Lawrence, Kansas, 1980), pp.191,197. A comprehensive assessment of his character is given in Chapter XI. See also, C. Martin, 'Lawson Tait, His Life and Work, with Personal Reminiscences', *Birmingham Medical Review* (June, 1931).

the key actors responsible for establishing some of the major surgical procedures, including 'ovariotomy' (surgery to remove one or both ovaries). This operation, highly controversial in the nineteenth century, has since remained the subject of much historical debate. Tait rose to international prominence through his skill at this and similar procedures. The primary aim, however, is to explore clinical practice at the Women's Hospital. Tait's texts, used extensively in this chapter, are immensely valuable in this respect. In *Diseases of Women* (1879), he records detailed accounts of the treatments he prescribed for his patients and the care they received.<sup>3</sup> His writing puts much of the detail of the archival records into context and reveals a more compassionate side of his nature than is sometimes presented. We turn first to a summary of Tait's early career, in which he laid the foundations of his technical skill.

Tait qualified LRCS and LRCP (Edin.) in May 1866, aged just 21 years.<sup>4</sup> The following year, he took a post as House Surgeon to the Clayton Hospital, Wakefield in the West Riding of Yorkshire.<sup>5</sup> In retrospect, the principles that marked Tait's future practice, a special interest in gynaecology and an innovative approach to surgery, were established in these early years. The Clayton Hospital provided Tait with the range of cases he needed to widen his clinical experience, and a degree of autonomy that allowed him to make full use of it.<sup>6</sup> This included his first attempts at gall-bladder surgery. A report, published in 1905, noted that, in 1868, Tait 'removed some gall-stones from a

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<sup>2</sup> R. Morantz-Sanchez, *Conduct Unbecoming a Woman. Medicine on Trial in Turn-of-the-Century Brooklyn* (New York and Oxford, 1999), p.99.

<sup>3</sup> L. Tait, *Diseases of Women* (2nd ed. New York, 1879).

<sup>4</sup> Shepherd, *The Rebellious Surgeon*, p.13.

<sup>5</sup> Martin, 'Lawson Tait', p.7.

<sup>6</sup> Shepherd, *The Rebellious Surgeon*, p.17.



suppurating gall-bladder by slitting up a sinus discharging from the umbilici.<sup>7</sup> During his time in Wakefield, Tait also carried out his first ovariectomies.<sup>8</sup> As will be discussed below, throughout the 1860s, the validity of this procedure was questioned by some within the profession. It is a measure of his supreme confidence that such a young and relatively inexperienced surgeon chose to undertake what was widely considered a dangerous operation. This provincial town in Northern England also provided Tait with the essential stepping-stones he needed to further his social and professional aims. Hilary Marland has shown that medical societies, medical libraries and scientific societies were important mediums through which nineteenth-century medical practitioners pursued their professional advancement.<sup>9</sup> Wakefield could boast a Microscopic Society, to promote microscopic inquiry in the field of medical sciences, and a Medical Book Club, which functioned as a circulating library.<sup>10</sup> This encouraged local practitioners to keep up to date with the latest developments and a number of medical men in Wakefield made their own contribution to the proliferation of new books and articles to medical journals.<sup>11</sup> Tait was no exception; he published many papers during his years in Wakefield, on a variety of topics, including a number on gynaecological disease.<sup>12</sup> It is evident that this enterprising young man was keen to make his mark and he had some success. In July 1869, he was invited to present a paper, on the management of a patient with complete inversion of the uterus, to the Obstetrical Society of

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<sup>7</sup> Mayo Robson's monograph on gallstones (1905). Cited *ibid.*, p.23. While this was not a direct exploration of a diseased gallbladder, the experience may have stimulated Tait's later interest in this aspect of abdominal surgery.

<sup>8</sup> Tait performed his first ovariectomy in July 1868 and four others before he left Wakefield in 1870. Martin, 'Lawson Tait', p.7.

<sup>9</sup> H. Marland, *Medicine and Society in Wakefield and Huddersfield, 1780-1870* (Cambridge, 1987), p.304.

<sup>10</sup> Cited *ibid.*, p.305

<sup>11</sup> *Ibid.*, pp.306-08.

London.<sup>13</sup> This paper excited a good deal of interest and earned him the respect of those practitioners working in the emerging speciality of gynaecology. Nevertheless, Tait retained a broad medical practice and acquired a reputation throughout Yorkshire as a physician and surgeon of some standing.<sup>14</sup> He had also achieved a position of some social importance and married the daughter of a local solicitor, Miss Sibyl Stewart.<sup>15</sup> After three years in Wakefield, opportunities for further progression were limited. This ambitious young man needed the stimulus of a larger medical community. London would have perhaps been the place of choice but, as discussed in Chapter One, personal friendships, family connections or professional networks largely dictated appointments to senior positions in the capital.<sup>16</sup> A large provincial town was a reasonable alternative, and Tait left Wakefield in 1870 and bought a small suburban general practice in Birmingham.<sup>17</sup>

There is no indication that Tait had any social or professional connections in Birmingham but it is likely that he was aware of the town's advantages. As we have seen, Birmingham was a thriving centre of industry and commerce and a town that welcomed innovative solutions to challenges, in whatever field of endeavour. A climate that embraced new ideas and methods was the ideal environment for Tait, who came to be known as the 'radical innovator in medicine'.<sup>18</sup> In addition to the voluntary hospitals mentioned in Chapter One, there was also a medical centre of some distinction. Birmingham was among

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<sup>12</sup> Shepherd, *The Rebellious Surgeon*, p.24.

<sup>13</sup> Ibid.

<sup>14</sup> Marland, *Medicine and Society*, p.277.

<sup>15</sup> Martin, 'Lawson Tait', p.7.

<sup>16</sup> M. Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley, Los Angeles and London, 1978).

<sup>17</sup> Martin, 'Lawson Tait', p.7.

<sup>18</sup> J. Elliot Sewell, 'Bountiful Bodies: Spencer Wells, Lawson Tait, and the Birth of British Gynaecology', PhD thesis, Johns Hopkins University, 1990, p.181.

the first provincial towns to establish a medical school (1828), and clinical training was available at the Queen's Hospital (purported to be the first purpose built teaching hospital in England), from its foundation in 1841.<sup>19</sup> Therefore, opportunities for Tait to progress his career were considerable but it was not an easy matter for a young, unknown practitioner to get a hospital appointment, which he needed to establish himself as a specialist.<sup>20</sup> As a first step, he abandoned his general practice and set up as a consulting surgeon, in the same building as Dr Bell Fletcher, the senior physician to the General Hospital.<sup>21</sup> Bell Fletcher provided an introduction to the local medical community but a more influential friend and mentor was the Reverend George Dawson. We have learnt of Dawson's role in promoting the 'civic gospel' that underpinned the political and social ethos of the town. He had also established the *Birmingham Morning News* as an organ for his personal views on social improvement.<sup>22</sup> To supplement his income, Tait wrote a number of articles for the paper and it is probable that he met Arthur Chamberlain through his friendship with Dawson. This association was the turning point in Tait's professional career and it would appear that it was also a time of personal re-evaluation. Although he enjoyed a fashionable lifestyle (he was known as a generous host and took great pleasure in associating with leading figures from the theatrical world), it is evident that Tait embraced many of Dawson's political and ideological ideas. His biographer and former colleague, Christopher Martin, recalls a sermon Tait delivered in the chapel of Church of the Saviour, on 'The Image of Baal'. He concluded that, from the views he expressed in that

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<sup>19</sup> J. Reinartz, 'Healthcare and the Second City: The Development of the Teaching Hospitals in the Nineteenth Century', *Birmingham Historian*, 26 (2004), p.19.

<sup>20</sup> Shepherd, *The Rebellious Surgeon*, p.30.

<sup>21</sup> Martin, 'Lawson Tait', p.7.



sermon, Tait had evidently adopted the Unitarian philosophy.<sup>23</sup> It is probable that these shared values underpinned the relationship between Tait and Chamberlain and helped to smooth what could have been a stormy relationship between two strong-minded men.

Like many Victorian medical practitioners, Tait had an interest in public health; this perhaps influenced his decision to stand as the Liberal candidate for election to the Town Council in 1876. On election, he was made a member of the Health Committee, a post he held until 1885.<sup>24</sup> Tait is on record as having a keen interest in the work of this Committee. He shared Chamberlain's concern about the unsanitary conditions on the streets, which he recognized as the source of the outbreaks of typhoid fever and diphtheria. During his time in office, he worked with the Medical Officer of Health to prepare a 'Disease Map' of the town.<sup>25</sup> Tait's text suggests that his work in this field almost certainly informed his thinking in diagnosing possible causes of infection. As in Wakefield, Tait took an active part in the wider medical community, including the provident dispensary movement in Birmingham.<sup>26</sup> In addition, Tait took a leading part in founding the Medical Defence Union and Birmingham Medical Institute, being elected its President in 1876.<sup>27</sup> During this period, Tait continued his practice of writing articles for the medical press and attended medical meetings in London, where he put forward his often unorthodox views.<sup>28</sup> Despite his uncompromising attitude, he began to occupy a leading

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<sup>22</sup> Sewell, 'Bountiful Bodies', p.191.

<sup>23</sup> Martin, 'Lawson Tait', pp. 7, 21. See, Shepherd, *The Rebellious Surgeon*, pp.149-51, for a detailed analysis of Tait's religious beliefs.

<sup>24</sup> H.F. Reichenfeld, 'The Birmingham Provident Dispensary Hockley Branch 1877-1948', *Birmingham Historian*, 21 (2002), p.20.

<sup>25</sup> Ibid. See also, Sewell, 'Bountiful Bodies', pp.248-49.

<sup>26</sup> See Chapter 2.

<sup>27</sup> Reichenfeld, 'The Birmingham Provident Dispensary', p.20.

<sup>28</sup> For example, his opposition to the antiseptic precautions advocated by Lister.



position in gynaecological circles.<sup>29</sup> Tait's greatest interest, however, lay in practising his art and it was fortuitous that the field of gynaecological surgery was ripe for development at the start of his own career.

The transition from the traditional remedies for women's disorders to surgical intervention began during the early decades of the nineteenth century. In spite of the new understanding of internal organs engendered by pathological anatomy, the modern practice of gynaecology could not advance without further developments in surgery.<sup>30</sup> Notwithstanding increasing knowledge and new techniques, the surgeon still faced major obstacles. Firstly, the inability to relieve pain during surgery increased the risk of shock. Consequently, in procedures requiring an abdominal approach, surgeons aimed for the greatest accuracy consistent with maximum speed. A further difficulty was wound infection. Before antiseptic (and later, aseptic) techniques were adopted, even 'successful' procedures almost inevitably resulted in local infection, which often progressed to fatal septicaemia.<sup>31</sup> The first of these hurdles to be overcome was the ability to control pain. The use of anaesthetic gases in general surgery has been attributed to the Boston dentist William Morton. In October 1846, Morton, having successfully used inhalation ether as a general anaesthetic in tooth extraction, was persuaded to demonstrate his inhaler to anaesthetise a patient undergoing surgery for a tumour on his neck.<sup>32</sup> The successful outcome of this operation, and a number of subsequent other cases in America, ensured that the practice soon spread to England. In

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<sup>29</sup> Shepherd, *The Rebellious Surgeon*, pp. 153-54. Tait was elected President of the British Gynaecological Society in 1886. He was the first provincial surgeon to hold high office in a national society.

<sup>30</sup> E.H. Ackerknecht, *Medicine at the Paris Hospital* (Baltimore, 1967), p.xi.

<sup>31</sup> E.H. Ackerknecht, *A Short History of Medicine* (Baltimore and London, 1982), pp.186-88.

<sup>32</sup> A.J. Youngson, *The Scientific Revolution in Victorian Medicine* (London, 1979), pp.42, 50-51.

January 1847, the *Lancet* described the new method as 'one of the most important discoveries of the present age' and promised to 'watch its development in the various branches (of medicine), which may admit its application'.<sup>33</sup>

Even before the widespread use of anaesthetics, innovative work had been done in gynaecological surgery to remedy some of the more serious causes of ill health in women. For example, by 1852, the American gynaecologist, J. Marion Sims, had developed the first reliable operation for vesico-vaginal fistula (a sequela of childbirth).<sup>34</sup> Contemporaries, professional and the wider public, lauded both J. Marion Sims's achievements in medicine and his founding of the Women's Hospital, New York, in 1855.<sup>35</sup> Medical historians also had high regard for Sims's clinical skill and expertise. Acknowledging that gynaecologists had been seeking a cure for vaginal fistula for a number of years, one authority credited Sims with changing the whole situation 'almost with a magic wand'.<sup>36</sup> Others have been more critical. In recent years, social historians of medicine have raised ethical issues regarding how gender, race and class influenced the medical treatment patients received.<sup>37</sup> Sims's medical career nicely illustrates the 'hero or villain' analogy described by Jacalyn Duffin.<sup>38</sup> Sims perfected his technique for vaginal repair by operating on black slaves, one of whom, Anarcha, had repeated surgery over a period of three and one-half years before she found any significant relief. McGregor has described

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<sup>33</sup> *Lancet*, 2 January 1847.

<sup>34</sup> Ackerknecht, *A Short History of Medicine*, p.193.

<sup>35</sup> A. Dally, *Women Under the Knife. A History of Surgery* (London, 1991), p.30.

<sup>36</sup> E.M. Jameson, *Gynaecology and Obstetrics* (New York, 1962), quoted *ibid.*, p.22.

<sup>37</sup> For a summary of competing views, see *ibid.*, Chapter II. A detailed and balanced account of J.Marion Sims's life and work is given by D. Kuhn McGregor, *From Midwives to Medicine. The Birth of American Gynecology* (New Brunswick, New Jersey and London, 1998).

<sup>38</sup> J. Duffin, *History of Medicine. A Scandalously Short Introduction* (Toronto, Buffalo, 1999), Chapter I.

the public nature of his operations, where spectators were invited to watch the procedures, notwithstanding the female nakedness and exposure of genitals.<sup>39</sup> McGregor notes also that anaesthesia was not administered to slaves, who were assumed to have a higher tolerance to pain than genteel white women.<sup>40</sup>

Sims's attitudes towards medical experimentation are emblematic of the racial and class prejudice amongst Southern whites in the antebellum years. He never questioned his right of absolute authority over his patients, or expressed moral uncertainty about his use of slaves. This does not mean that we should affix modern idioms, such as 'racist', to Sims or his Southern colleagues, however. Expressions that belong to the present do not expose the historical significance of those biases.<sup>41</sup> The practice of medicine in the nineteenth century reflected the dominant social and moral order of the time. Social, political and economic worth were denoted by a racial hierarchy that accommodated surgical experimentation on slaves. Thus, as McGregor has argued, an ethical probing of Sims's career requires sensitivity regarding the depth of racial and class biases inherent in nineteenth-century surgical practice.<sup>42</sup> Notwithstanding the profound integration of social and moral values in the practice of medicine, it would be wrong to assume that all physicians had the same perception of racial differences. There was a body of opinion, in the American School, that questioned physiological parallels between races. Practising physicians like Sims, usually disregarded race as a central factor in medical therapies. As McGregor has observed, in order to transpose his cure of Mrs Merrill, a white woman, to the treatment slaves he must have 'assumed

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<sup>39</sup> McGregor, *From Midwives to Medicine*, p.46 ff

<sup>40</sup> *Ibid.*, pp. 50-51.

<sup>41</sup> *Ibid.*, pp. 56-57.

<sup>42</sup> *Ibid.*, p.57.



that the female anatomy was homologous between whites and blacks'.<sup>43</sup> We have no way of knowing how Anarcha and her fellow sufferers felt about their role in Sims's innovative, untried surgery, but McGregor has proposed that we can only take the patient's participation as indicating a 'modicum of willingness' and perhaps preferable to their life on the plantation.<sup>44</sup> Harriet Jones, a woman who had lived as a mother in slavery, wrote 'Slavery is terrible for men; but it is far more terrible for women. Superadded to the burden common to all, *they* have wrongs and sufferings, and mortifications peculiarly their own.'<sup>45</sup>

As will be discussed further in the following chapter, vaginal fistulae were also common in England. According to Lawson Tait, this condition, when not caused by cancerous ulceration, was usually the result of continuous, long-sustained pressure of the foetal head in labour. Many of the cases arose from the want of efficient assistance in labour or the 'inexcusable delay on the part of the *accoucheur* in assisting the natural efforts by instrumental interference'.<sup>46</sup> Some, however, were inevitable and interestingly, Tait makes a distinction between fistulae that occurred in the first pregnancy, and those occurring in subsequent pregnancies. The great majority of those in the first category were found amongst young women of the 'humbler classes'.<sup>47</sup> The damage was often far-reaching; Tait describes one case where the whole of the vaginal wall was destroyed by sloughing. This, and similar cases he attributed to such patients 'concealing as long as possible, the fact they are in labor, they being

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<sup>43</sup> Ibid.

<sup>44</sup> Ibid., p.54.

<sup>45</sup> H.A. Jacobs, *Incidents in the Life of a Slave Girl: Written by Herself*, J. Yellin (ed.) (Cambridge, Mass, 1987), p.77. Cited *ibid.*, p.40.

<sup>46</sup> Tait, *Diseases of Women*, p.43.

<sup>47</sup> Ibid.



unmarried'.<sup>48</sup> In married women, especially in multiparae, the fistulae were altogether of a different nature.<sup>49</sup> Here the damage was seldom extensive, although the site of such fistulae often made them very difficult to remedy. Other than the type of procedure performed, there is no suggestion that any distinction was made in the medical care of the two groups. Indeed, Tait's approach to unmarried women was unusually sympathetic for his time. In 1871, he wrote a formal letter of complaint to the Chairman of the Lying-in Charity, regarding their refusal to admit a case 'on the grounds that the poor girl was unmarried'.<sup>50</sup> The Chairman pointed out that, as was the usual practice in the nineteenth century; the Lying-in Charity was founded to help 'poor married women in their confinements'.<sup>51</sup> Tait was adamant; there was nothing in the rules of the Charity that justified such a refusal and he would withdraw his support from the Charity unless it was made clear that the rules did not exclude unmarried women.<sup>52</sup>

There are many other instances of Tait's down-to earth approach to all matters of a sexual nature and his practice in this aspect of gynaecological disease was often in marked contrast to some of his peers. For example, masturbation was a cause of increasing anxiety in nineteenth-century Britain and America, a phenomenon historians have linked to the increasing anxiety around female sexuality at this time.<sup>53</sup> As noted in the introduction to this thesis, Baker Brown had purported to have found a cure for this 'disorder',

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<sup>48</sup> Ibid.

<sup>49</sup> 'multiparae', a woman who has had more than one child.

<sup>50</sup> S. Tait, 'The Pioneers', unpublished paper to record the history of the hospital at the time of its centenary in 1971, held at the archives of the Birmingham Medical Institute.

<sup>51</sup> Birmingham City Archives (hereafter, BCA), Archive of The Lying-in Hospital, HC/MH 1/1/1, Annual Report, November 1867.

<sup>52</sup> Tait, 'The Pioneers'.

<sup>53</sup> Dally, *Women Under the Knife*, pp.162ff, O. Moscucci, *The Science of Women. Gynaecology and Gender in England 1800-1929* (Cambridge, 1990), p.105.

claiming that the logical solution to masturbation was surgical removal of the clitoris. Following an inquiry into the validity of clitoridectomy, Baker Brown was subsequently expelled from the Society on 3 April 1867, on the grounds of unprofessional behaviour.<sup>54</sup> Thereafter, clitoridectomy was discredited in England, but evidently medical opinion remained divided on the management of masturbation. Tait rebuked his peers for refusing to have an open discussion on the subject, which made it difficult to determine to what extent it prevailed, how to identify its victims, or to suggest an appropriate remedy. He complained that this 'painful subject' was spoken of so seldom that it was surrounded in mystery. Consequently, when it was discovered it struck everyone with such horror that the matter was hushed up, 'instead of being treated, as it always ought to be, as a disease'.<sup>55</sup> Tait considered it a 'sad misfortune that all sexual questions are so completely hidden from children at puberty that they are driven to make discoveries for themselves'.<sup>56</sup> For either sex, Tait held that the evil effects of masturbation had been greatly overrated. Although it did occasionally result in 'serious mischief' for men, in women, he believed the practice was 'not often carried out to such an extreme to do any harm'.<sup>57</sup> In the rare, inveterate case Tait thought it possible that clitoridectomy might be beneficial, but he had never tried it. The best remedy was to explain the nature and purpose of the functions they were abusing, and advise them of the risks attached to it.<sup>58</sup>

Clitoridectomy played only a small part in the history of surgical gynaecology; its significance lies in its expression of an ideology that limited

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<sup>54</sup> Dally, *Women Under the Knife*, pp.178-79.

<sup>55</sup> Tait, *Diseases of Women*, p.29.

<sup>56</sup> *Ibid.*

<sup>57</sup> *Ibid.*, p.30.

female sexuality to reproduction.<sup>59</sup> Moreover, despite the demise of the procedure, the hypothesis that linked the clitoris to insanity and other diseases remained current. Throughout the nineteenth century, it was widely assumed that women's biological functions governed their physical and mental health. In 1882, Robert Barnes explained that it was impossible to separate 'the special diseases of women from the domain of general pathology'.<sup>60</sup> It followed that any disease occurring in women, whatever its seat of origin, would almost certainly affect her sexual system. On the other hand, 'the ordinary or disturbed work of her sexual system will influence the course of any disease which may assail her'.<sup>61</sup> On this assumption, any malposition of the uteri, or that of the cervix as its mouth and neck, caused the signs and symptoms of disease in various organs of the body, notably those of the reproductive system. The 'cure-all' surgery for uterine disorders, such as dysmenorrhoea and pelvic inflammation, was incision and/or excision of the cervix uteri, to correct the displacement, a procedure pioneered by Sims and his colleague, Thomas Emmet.<sup>62</sup> Simms and Emmet both claimed to have performed the operation of cutting open the os and cervix 'many hundreds of times' for various reasons, the rationale of which changed over time.<sup>63</sup>

The idea that a displaced uterus indicated the need for urgent surgery was not universally accepted. Spencer Wells questioned the utility of Sims's incision of the cervix, a procedure he considered both dangerous and

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<sup>58</sup> Tait, *Diseases of Women*, p.30.

<sup>59</sup> Dally, *Women Under the Knife*, p.163.

<sup>60</sup> Moscucci, *The Science of Women*, p.104.

<sup>61</sup> Ibid.

<sup>62</sup> McGregor, *From Midwives to Medicine*, pp.143-44.

<sup>63</sup> Ibid., p.149.

fruitless.<sup>64</sup> Others were more outspoken; the German surgeon, Theilhaber, created enormous hostility within the profession by declaring that, in his opinion, 'the symptoms ascribed to retroversion of the uterus (backache, abdominal pain, haemorrhage, leucorrhoea, bladder disturbance, nervousness, difficult periods and sterility), were actually due to other conditions.'<sup>65</sup> Lawson Tait found the differing views on this 'really simple subject' amusing; in *Diseases of Women* (1879), he noted 'one eminent gynaecologist seems to discover a flexion or version in every patient he sees (whilst) in the practice of another equally eminent specialist, no flexions or versions ever seem to occur'.<sup>66</sup> To avoid confusion, and to restore credibility to the profession, he advised looking at the matter of uterine displacements with the aid of 'the light which Simpson's strong common sense has thrown upon them'.<sup>67</sup> Tait paid a good deal of attention to detailing the difference in diagnostic terms, and the possible causes of displacements of the uteri. He was sceptical, however, about the number of women reputedly suffering from 'malpositions' and cautions that to treat a condition 'unless there are very definite symptoms associated with it, is the merest charlatanry'.<sup>68</sup>

Certainly, the condition was common; a total of 106 women who attended the out-patient department of the Women's Hospital between October 1871 and February 1872, were diagnosed as having some form of displacement of the uterus.<sup>69</sup> An analysis of the in-patient registers reveals, however, that few were admitted for treatment, with only three such cases being recorded in the

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<sup>64</sup> McGregor, *From Midwives to Medicine*, p.152.

<sup>65</sup> Dally, *Women Under The Knife*, p.144.

<sup>66</sup> Tait, *Diseases of Women*, p. 81.

<sup>67</sup> Ibid.

<sup>68</sup> Ibid., p.82.



first year.<sup>70</sup> The early records note only the diagnosis and outcome of treatment, but some indication of the therapies such women received can be gleaned from the writings of Tait. Unlike many gynaecologists, in *Diseases of Women* Tait did not discuss the management of uterine displacement *per se*. In many cases, he claimed, where no suffering had been experienced, displacements required 'no treatment whatever'.<sup>71</sup> When treatment was required, its details differed in every case. For example, for a patient suffering from chronic ovaritis, he advised the use of iodine paint and the occasional washing out of the uterine cavity with a weak solution of neutral acetate of lead. Tait also prescribed a tonic mixture consisting of cinchona and angostura, to which he later added 'small doses of iron, in the form of drops of Parrish's syrup of the phosphates, taken thrice daily'.<sup>72</sup> The co-existing retroflexion of the uterus was 'easily reduced' and the position maintained by the insertion of a ring pessary.<sup>73</sup>

Some headway had also been made in the management of another common condition, ovarian cysts. The history of ovarian surgery, often described using the contemporary term, ovariectomy, affords perhaps the clearest example of the changing nature of gynaecological practice. The possibility of removing ovarian cysts had been suggested early in the nineteenth century by Charles Bell, who predicted that the future of all abdominal surgery lay in this and similar procedures.<sup>74</sup> Bell did not contemplate undertaking such a course himself however; any operation that

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<sup>69</sup> BCA, Archives of The Birmingham and Midland Hospital for Women (hereafter BMHW), HC/WH 1/5/1, Medical Committee, March 1872.

<sup>70</sup> Ibid., HC/WH 3/1/1, In-Patient Register, 1871-1892.

<sup>71</sup> Tait, *Diseases of Women*, p.85.

<sup>72</sup> Ibid., p.132.

<sup>73</sup> Ibid.

involved opening the peritoneum was highly controversial and strictly forbidden in many medical institutions.<sup>75</sup> Thus, the early cases that have been recorded were usually undertaken in severe cases, to avoid almost certain death.<sup>76</sup> From the 1840s, there was a move towards elective procedures, with Charles Clay in Manchester and Isaac Baker Brown in London both undertaking a series of planned ovariectomies.<sup>77</sup> The first results were not encouraging. Thomas Inman's 'Tables of the mortality after operations', collated in 1844, showed 42 cases of ovariectomy with 14 deaths, a mortality rate of 33.3 per cent.<sup>78</sup> This was approximately the same as the mortality rate for amputations (31.9 per cent), or tying large arteries (33.1 per cent).<sup>79</sup>

The poor results may have been due to the desperate nature of the cases involved. Some of the women included in the mortality statistics were reported to have such massive ovarian cysts that pregnancy had been the initial diagnosis.<sup>80</sup> It is probable that other women were in a similar state of poor health. The case notes of Spencer Wells describe unfortunate women 'doomed to a slow death, emaciated and asphyxiated by monstrous fluid-filled sacs'.<sup>81</sup> Those opposed to the procedure argued that it was pointless to submit such patients to radical surgery, when they had such poor prospects of recovery. It was also suggested that the inaccuracy of the diagnosis was a further

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<sup>74</sup> Dally, *Women Under the Knife*, p.11.

<sup>75</sup> Ibid. Other than follicular cysts associated with ovulation, ovarian cysts may give rise to a number of complications, including torsion, rupture, causing intense pain and pelvic peritonitis, pressure symptoms and loss of weight. There is also a need to exclude malignancy.

<sup>76</sup> Sewell, 'Bountiful Bodies', p.113, Dally, *Women Under the Knife*, pp.15-16.

<sup>77</sup> Clay is held to be one of the leading ovariectomists of his period. He published his statistical results in *Medical Times*: 7, 1842. Seven of the nine patients operated on by Baker Brown between 1852 and 1856 died. Sewell, 'Bountiful Bodies', p.115.

<sup>78</sup> T.Inman, 'Tables of the mortality after operations', *Lancet*, 2 (1844), pp.39-40. Cited Moscucci, *The Science of Women*, p. 138 and Table 4, p.210. The tables of mortality refer to all capital operations, i.e. those likely to involve loss of life. The figures refer to all known cases.

<sup>79</sup> Ibid.

<sup>80</sup> Sewell, 'Bountiful Bodies', p.116.

indication of ovariectomy's illegitimacy.<sup>82</sup> Nevertheless, the early cases did demonstrate that the procedure was technically possible and a number of eminent surgeons, including James Young Simpson, asserted that the operation was 'an eminently justifiable procedure when no other measure could save a woman's life'.<sup>83</sup> Spencer Wells shared Simpson's faith in the procedure and his conviction that operative mortality rates could be reduced.<sup>84</sup> In December 1857, Wells made his first attempt to treat an ovarian cyst surgically. Wells was persuaded to abort that operation, due to complications. The patient died shortly afterwards, from the cyst that Wells was convinced he could have removed. Three months later, in 1858, Wells operated on a young woman who had been conservatively treated for eight years; it was to be his first successful ovariectomy.<sup>85</sup> This marked the beginning of a series of operations that, over time, established ovariectomy as an acceptable procedure. In part, this was due to the reduction in mortality rates he achieved, from around 34 per cent in 1865 to 20 per cent in 1872.<sup>86</sup> As Jane Sewell has shown, however, Wells was also a successful propagandist, presenting papers to medical societies and publishing extensive reports of his ovariectomy cases in the medical press.<sup>87</sup> These activities did much to establish both his professional career, and his reputation as one of the leading ovariectomists of his time.

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<sup>81</sup> Ibid., p.268.

<sup>82</sup> Ibid., pp.116, 268-69, Moscucci, *Science of Women*, pp.138-39.

<sup>83</sup> J. Young Simpson, *Medical Times and Gazette* 41 (1860), p.231. Cited *ibid.*, p.119.

<sup>84</sup> T. Spencer Wells, 'On Some Causes of Excessive Mortality Rates After Surgical Operations', a paper read before the British Medical Association, Cambridge, August, 1864 (London, 1877), p.35. Cited *ibid.*, p.117.

<sup>85</sup> Ibid., pp.120-21. Conservative treatment meaning non-operative. Other than surgery, no treatment available at that time would have been effective.

<sup>86</sup> Ibid., p.124.

<sup>87</sup> Ibid., pp.122-24.



The move to such major procedures at the Women's Hospital was a gradual process. With only eight beds available in the early years, priority for admission to the Institution was given to those whose conditions could be cured, or afforded some relief (meaning a significant improvement in their condition) in a reasonable amount of time. Of the first one hundred cases, around twenty-five per cent of patients had ovarian tumours or fibroids; a further six cases were diagnosed as cancer. Eleven women had complications of childbirth, including eight with a ruptured perineum. Some conditions were non-gynaecological, such as rectal disorders and disease of the breast, but an early decision had been made to accept women whose conditions might be a cause of embarrassment in a general hospital.<sup>88</sup> Cases, such as cancer and ovarian cysts and tumours, required major procedures and it is probable that amongst these we may count the two cases of ovariectomy reported by Morantz-Sanchez. Both were performed by Tait in 1872, the first to remove a chronically abscessed ovary, the second, a few months later, where bilateral ovariectomy was performed to cure a case of bleeding fibroid tumours.<sup>89</sup> The results of such surgery were not promising. In December 1875, the Medical Board reported that, of the 30 operations for ovarian disease 15 cases had been successful but 15 patients had died. Of five other operations 'similar but a greater danger to life' (three for ectopic gestation and two for fibroid tumours), only two were successful.<sup>90</sup>

A 50 per cent mortality rate for ovariectomy was significantly higher than the 20 per cent that Spencer Wells had achieved by 1872.<sup>91</sup> In part, the difference

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<sup>88</sup> BCA, BMHW, HC/WH 1/5/1, Medical Board, March 1872.

<sup>89</sup> Morantz-Sanchez, *Conduct Unbecoming a Women*, p.95.

<sup>90</sup> BCA, BMHW, HC/WH 1/5/1, Medical Board, October 1875.

<sup>91</sup> Sewell, 'Bountiful Bodies', p.124.



in performance can be accounted for by the experience Spencer Wells had acquired during the 1860s. His expertise in this field was openly acknowledged by Tait, who praised Spencer Wells for his foresight in conscientiously recording the details of his surgery. Tait concluded that this data had been 'so critically examined', and the conclusions 'so irresistibly drawn, that there is from it at present no appeal'.<sup>92</sup> Full of warmth for the man, who at that stage in his career, was his friend and mentor, Tait accorded Wells credit for establishing the procedure of ovariectomy as 'one of the most successful of the great operations of surgery'.<sup>93</sup> A successful outcome could not be guaranteed however. The proper selection of cases was just one of the difficulties faced by the surgeon. Patients' histories varied enormously and could be misleading; furthermore, the symptoms of a number of other conditions could mimic those of ovarian tumours. Tait advised that the best plan was to take a careful history of every symptom and every sign and then proceed to exclude every other possible condition, until no alternative diagnosis could be made. Having confirmed the diagnosis of ovarian tumour beyond reasonable doubt, Tait held that there were only two reasons not to do an ovariectomy. One, that the case was not far enough advanced or secondly, 'that the tumour in all probability could not be removed'.<sup>94</sup> Acting on this principle, Tait acknowledged that he had operated on a number of cases 'where the chances of recovery were very small'.<sup>95</sup> On the other hand, he had seen such cases recover and he scorned those surgeons who selected cases purely with a view to a good mortality bill.<sup>96</sup>

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<sup>92</sup> Tait, *Diseases of Women*, p.165.

<sup>93</sup> *Ibid.*, pp.165-66.

<sup>94</sup> *Ibid.*, p.166.

<sup>95</sup> *Ibid.*

Nevertheless, it is interesting to note that such disappointing results were made public; few other institutions published the results of their operations in such detail. In their first annual report, the medical staff had predicted that statistics would be 'of great scientific value' as they accumulated.<sup>97</sup> Certainly, surgeons utilized statistical evidence to demonstrate the efficacy of new procedures.<sup>98</sup> It is likely, however, that the maintenance of careful records can be attributed to Arthur Chamberlain. As shown in Chapter One, Chamberlain had demonstrated his interest in statistical data by his comparative analysis of women's hospitals at the first public meeting in 1871. His business acumen also determined that the Charity was to be as well managed as any public institution in the town and as efficient as any commercial undertaking. Critically, the success of the hospital was to be measured, not by the number of attendances but 'rather by the money spent per patient cured'.<sup>99</sup> At the annual meeting in 1902, Chamberlain called attention to the fact that 'this hospital presented regularly, and had done every year of its thirty years existence, statistics showing the results of their operations'.<sup>100</sup> Chamberlain thought that such a policy should be adopted by others, particularly the 'larger and older institutions' in the town. Too often, he claimed, annual meetings appeared to be merely a forum to discuss 'the number of patients they had received, the amount of money they had spent, the much larger amount they would liked to have spent, and a general congratulation amongst themselves

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<sup>96</sup> Ibid.

<sup>97</sup> BCA, BMHW, HC/WH 1/10/1 Annual Report, March 1872.

<sup>98</sup> Spencer Wells utilized statistical evidence of his declining mortality rate as propaganda in presenting the case for ovariectomy. See Sewell, 'Bountiful Bodies', pp.122-23.

<sup>99</sup> BCA, BMHW, HC/WH 1/10/1, Annual Report, March 1872.

<sup>100</sup> Ibid., HC/WH 1/10/4, Annual Report, March 1902.

on their charity and their goodness'.<sup>101</sup> He pointed out that the aim of medical charities was not to get the largest number of the suffering poor through their doors. Rather, what people really needed to know was how many they had done the utmost good for 'that was possible by our present medical and surgical knowledge'.<sup>102</sup> Chamberlain acknowledged that imparting such information required a degree of openness that could be uncomfortable. At the annual meetings, the hospital had often attracted a good deal of criticism when they reported poor results. This he accepted, so long as it was honest and constructive, 'it was wise that they should listen to it and learn from it'.<sup>103</sup>

Notwithstanding the unpromising results reported in 1875, there is no evidence to suggest that there was a loss of confidence in the Institution. Indeed, Jonathan Reinartz has argued that 'the staff's openness with even their poorest results helped staff retain a certain amount of public support'.<sup>104</sup> A possible explanation for this phenomenon is that women were acutely aware of the risks involved but had few alternatives. As Morantz-Sanchez has pointed out, whilst abdominal surgery carried a high risk of uterine haemorrhage, mortality rates for untreated large fibroid tumours could be as high as 90 per cent.<sup>105</sup> From his writings, it would appear that Tait was open with his patients and gave them his candid opinion as to their chances of a successful outcome. Even with a poor prognosis, he found most women elected 'to have a chance of life *with a cure*, rather than the mere prolongation of a miserable life for a few months, with a horrible death at the end'.<sup>106</sup> The

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<sup>101</sup> Ibid.

<sup>102</sup> Ibid.

<sup>103</sup> Ibid.

<sup>104</sup> Reinartz, 'Healthcare and the Second City', p.23.

<sup>105</sup> Morantz-Sanchez, *Conduct Unbecoming a Woman*, p.100.

<sup>106</sup> Tait, *Diseases of Women*, p.166.

courage of the surgical profession in pressing forward with challenging, innovative surgery was therefore nothing to that of the women who were willing to participate in what was still surgery at an experimental stage.

Time and greater experience, would allow the respective surgeons time to break new ground in their field, although significant changes were required before this could be achieved. Perhaps in the spirit of 'listening and learning' the medical staff acknowledged a need to examine their practice. In what can best be described using the modern term 'guidance on best practice', a protocol was devised, to which all operating staff had to adhere. Firstly, and presumably to ensure the planned procedure was necessary and appropriate, a consultation of all the medical staff was required on any patient needing surgery, and a record of that consultation to be kept. Secondly, all operations were to be recorded, according to an agreed formula, in an 'operation book'. This was to include patients operated on in the hospital and those carried out in the patient's own home. Further, post-mortems were to be carried out on any post-operative death, by a duly qualified pathologist. Finally, all members of the medical staff were required to attend Medical Board meetings once a month, to consider the pathologist's report.<sup>107</sup> We have noted above, Tait's interest in autopsy and he makes frequent reference in his texts to the valuable lessons that could be learned from pathological evidence, particularly in the management of ovarian disease.<sup>108</sup>

The recognized causes of acute inflammation of the ovaries at that time were those resulting from physical injury, gonorrhoeal infection, septic

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<sup>107</sup> BCA, BMHW, HC/WH 1/5/1, Medical Board, November, 1877.

<sup>108</sup> Tait, *Diseases of Women*, pp.134-37.



poisoning in the post-natal period or as a sequela to acute fevers.<sup>109</sup> Tait thought that insufficient attention had been given to this latter group. Recording the experience he gained during the epidemic of smallpox in Birmingham from 1872 to 1874, he described four cases of pelvic infection, which ultimately proved to be cases of smallpox.<sup>110</sup> Of greater significance was the incidence of gonorrhoea. This condition was frequently a cause of sterility in woman but could have even more serious consequences. Tait records the case of a young wife infected by her errant husband, shortly after their marriage. The husband's disease proved 'very trifling' and his symptoms passed off in less than a week. The wife was less fortunate; although her health improved in a matter of weeks, she never fully recovered from a second attack. This young woman continued her married life a semi-invalid, seldom free from pain and 'quite unable to endure marital intercourse'.<sup>111</sup> The diagnosis of chronic ovaritis was more problematic. As Tait noted, although a common disease, there was little in the writings by the authorities in gynaecology concerning chronic inflammation of the ovary. In an effort accurately to describe, diagnose and treat the condition, Tait grouped the symptoms of a large number of cases. He concluded that the majority of cases occurred from 'sexual excess and masturbation, or as a sequela of exanthemata and rheumatic fever, and probably of syphilis'.<sup>112</sup> Other causal factors included those occurring as a consequence of acute ovaritis, chronic metritis, phthisis (tuberculosis), and occasionally after smallpox or scarlet fever.<sup>113</sup>

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<sup>109</sup> Ibid, p.130.

<sup>110</sup> Ibid.

<sup>111</sup> Ibid, p.129.

<sup>112</sup> Ibid.

<sup>113</sup> Ibid., p.127.

By the early 1880s, Tait had achieved international recognition for his innovations in gynaecological surgery, although not before he and his colleagues had faced some challenging years. The high mortality rates reported in 1875 failed to show any significant improvement and the medical staff suggested that this was due to inadequate facilities, owing to the growing requirements of the hospital. Although the medical staff had considered the facilities in the out-patient department to be 'the best of any women's hospital in Britain' when the Institution opened, they evidently now regarded them unsatisfactory.<sup>114</sup> The consulting rooms were too small, the lighting was poor and, lacking any form of ventilation, the rooms were unhealthy.<sup>115</sup> The debate around the out-patient accommodation continued over the ensuing months as the problem became more acute. By April 1875, the Management Committee were forced to admit that the situation was critical, as it was 'impossible to provide proper space and ventilation, or to maintain order in the waiting room, or to protect patients from draughts and cold'.<sup>116</sup> Overcrowding was the greatest problem; the number of women attending, already thought to be unmanageable, had increased over 20 per cent on the previous year.<sup>117</sup> In commenting on the situation in their Annual Report (1875), the Committee asked subscribers to bear in mind that the 'Hospital' was merely two ordinary dwelling houses, 'without the structure and appliances by which hospital infection may be avoided, or its removal facilitated'.<sup>118</sup> It had been started by way of an experiment and, if successful, it was evident that the current building would soon prove unsuitable. The only possible remedy was new

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<sup>114</sup> BCA, BMHW, HC/WH 1/10/1, Annual Report, 1872.

<sup>115</sup> Ibid., HC/WH 1/1/1, Board of Governors, 5 August 1873.

<sup>116</sup> Ibid., HC/WH 1/10/1, Annual Report, April 1875.

<sup>117</sup> Ibid.

accommodation for both departments, which would allow the hospital to move forward to a new stage in its development. The committee proposed to launch an appeal to that effect.<sup>119</sup>

Discussions on re-locating the out-patient department continued throughout the spring of 1876, to no avail; thereby, they had to continue at the present site. Of greater and more immediate concern were the wards which had become infected. The Medical Board impressed upon the management the urgency of the situation and declared that no patients could be admitted to the hospital whilst the wards remained in their present state. It was proposed that, as a temporary measure, patients could be treated in their lodgings.<sup>120</sup> This ultimatum appears to have been effective. Admissions were halted, the wards vacated and thoroughly cleaned. To reduce the risk of further cross infection, it was agreed to build three new wards, in the back yard of the current building, specifically for major surgery.<sup>121</sup> As a further precaution, the new wards were to be 'whitewashed after every ovariectomy case treated in them'.<sup>122</sup> Clearly, this was to no avail, as the new wards were soon infected too. Following poor results after several major operations, the medical staff concluded that it was 'undesirable for the present' to admit any but the 'less formidable cases'.<sup>123</sup> No one is blamed in contemporary records for the cause of the infection and it is difficult to do so retrospectively. Certainly, it was a source of tension between the Governors and medical staff. Several suggestions from the Management Committee, such as sharing accommodation with other medical charities, was

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<sup>118</sup> Ibid.

<sup>119</sup> Ibid.

<sup>120</sup> Ibid., HC/WH 1/1/1, Board of Governors, 2 May 1876.

<sup>121</sup> Ibid., HC/WH 1/5/1, Medical Board minutes 1875-76.

<sup>122</sup> Ibid., HC/WH 1/1/1, Board of Governors, 12 September 1876.

<sup>123</sup> Ibid., HC/WH 1/5/1, Medical Board, April 1877.

rejected by the medical staff on the grounds of possible cross infection.<sup>124</sup> The Governors objected to medical staff working at other institutions on similar grounds. A proposal by the Governors, that they might admit one patient at a time into the new wards, was rejected. Tait was adamant that he would not operate in these dangerous circumstances.<sup>125</sup> Chamberlain was also determined that lives would not be uselessly sacrificed due to some fault in the management of the Institution. It is equally problematic to attribute blame to the medical staff. Although sceptical about Lister's theory of antisepsis, Tait recognized the general principle laid down by Lister that the infection of wounds was caused by living organisms and that 'in one minute could cause bodily sepsis'.<sup>126</sup> Accordingly, Tait was scrupulous regarding hygiene. Following Syme and Simpson, he believed that absolute cleanliness, in person and equipment and an unpolluted atmosphere were the essential prerequisite of any surgical technique. Before operating, he scrubbed his hands with soap and water and wore a large mackintosh apron. He sterilized his instruments and prepared his silk sutures in a similar way. Tait also discounted Lister's carbolic dressings, preferring Gamgee's system of dry wool dressing.<sup>127</sup>

It is probably sensible, therefore, to consider the problem of infection in the context of the national concern around mortality levels and 'hospital diseases' that was current at this time. Tait was certainly aware of the debate, and published a book on hospital mortality, based on Simpson's theory that hospital

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<sup>124</sup> Ibid., HC/WH 1/1/1, Board of Governors, 1874-76.

<sup>125</sup> W.B. Gough, 'The Birmingham and Midland Hospital for Women, 1871-1972', booklet produced to celebrate the centenary of the hospital, p.4. Copy held at Birmingham Medical Institute.

<sup>126</sup> L. Granshaw, 'Upon This Principle I Have Based A Practice: The Development And Reception Of Antisepsis In Britain, 1867-90', in J. V. Pickstone (ed.), *Medical Innovations in Historical Perspective* (New York, 1992),



mortality had increased due chiefly to the growth trend towards 'huge and colossal hospital edifices' and the mortality rate attending them.<sup>128</sup> Accordingly, when Miss Ryland offered the Charity the premises in Sparkhill for a new hospital, a good deal of thought was put into the design of the accommodation. Housed in what was then a rural area on the outskirts of the town it was a perfect opportunity to incorporate some of Florence Nightingale's ideas about the importance of hospital hygiene and adequate ventilation.<sup>129</sup> A central feature of the new hospital was the separation of the main in-patient department from the accommodation for patients undergoing major abdominal surgery. As mentioned in Chapter One, shortly after the hospital opened, in 1878, an appeal was launched to build four special 'cottage wards', for patients undergoing treatment for 'ovarian and kindred tumours'. These small pavilion-style wards provided each patient with a separate room, where the 'pure air and perfect quiet', deemed necessary for a satisfactory post-operative recovery, could be assured.<sup>130</sup> It would appear that the new arrangements were successful as there was a marked improvement in the mortality rate. By September 1880, the Management Committee was able to report that since moving to the new accommodation, sixty major operations had been performed, with only three deaths.<sup>131</sup>

It is from this period that we note a significant increase in the amount of major surgery performed. By 1882, such operations accounted for 47.3 per

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<sup>127</sup> Lawson Tait, 'Details Necessary in the Performance of Abdominal Section', *Lancet*, 12 September 1891, pp. 597-99. In this article Tait describes in detail his operating technique. The emphasis on keeping the wound clean and dry anticipated later practice.

<sup>128</sup> Lawson Tait, *Hospital Mortality* (London, 1877). Cited Martin, 'Lawson Tait', p.9.

<sup>129</sup> Tait did not ascribe to Nightingale's theory on contagion, but the measures she advocated to 'banish' infection were widely adopted by medical men. See, Granshaw, 'Upon This Principle I Have Based a Practice', p.19.

<sup>130</sup> BCA, BMHW, HC/WH1/1/1, Appeal for Special Cottage Wards for the Treatment of Ovarian and Kindred Tumours, Board of Governors, 3 September 1878.

cent of Dr Savage's operating list and almost 70 per cent of Lawson Tait's list.<sup>132</sup> Although a wide range of surgical procedures were undertaken, operations involving the ovaries and fallopian tubes predominated. The work of the early ovariologists in establishing the utility of this procedure has been described above. By 1872, the operation had been accepted by many within the medical profession as a safe and effective treatment for ovarian tumours and cysts. It was Robert Battey's operation to remove healthy ovaries, in order to create a surgical menopause, which brought the procedure once more into disrepute. Because this operation profoundly influenced gynaecological practice for a decade or more, I shall record the details of this case. In 1865, a 23 year old woman, Julia —, consulted Battey for secondary amenorrhoea, accompanied by severe mental and physical symptoms, at the time the menstrual period would have occurred. Battey diagnosed endometriosis and treated her conservatively, with intrauterine silver nitrate and other measures, with little effect.<sup>133</sup> Some seven years later there was still no improvement in the patient's condition and Battey suggested the idea of a 'normal' ovariectomy as a radical cure. He reached this decision after a period of 'long and deliberate contemplation', seeking advice from several noted gynaecologists on the propriety of the procedure.<sup>134</sup> Longo does not record the outcome of his consultations, but there does not appear to have been strong opposition, as Battey went ahead with the planned operation on 17 August 1872. The patient made a full recovery, and, within a month, Battey published details of this

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<sup>131</sup> Ibid., HC/WH 1/1/1, Board of Governors, 7 September 1880.

<sup>132</sup> Ibid., HC/WH 1/10/2, Statistical Table IV, Annual Report, 1882.

<sup>133</sup> L.D. Longo, 'The Rise and Fall of Battey's Operation: A Fashion in Surgery', in J. Walzer Leavitt (ed.), *Women and Health in America: Historical Readings* (Madison, Wisconsin and London, 1984), p.271.

<sup>134</sup> Ibid.

operation in local medical journals.<sup>135</sup> Battey was not, however, the first to perform this procedure. Coincidentally, two other surgeons had removed 'small' ovaries (i.e. non-cystic), at about the same time. Professor Hegar of Freiburg is recorded as having 'removed both ovaries for neuralgia' on July 27 1872.<sup>136</sup> Five days later, Tait performed an ovariectomy, to arrest an 'intractable menstrual haemorrhage'.<sup>137</sup>

Within a decade, the procedure was gaining in popularity and, at the 1881 International Medical Congress in London, 193 cases of bilateral oophorectomy, by 47 different operators, were reported'.<sup>138</sup> Battey made several attempts to outline the indications for surgery, although, importantly, he held that the presence of ovarian pathology was not essential. In general terms, he presented his procedure as a '*dernier resort* for desperate cases' that were incurable by less radical means.<sup>139</sup> This lack of clarity in defining the type of cases suitable for this operation allowed the procedure to be widely abused. Convulsive disorders and insanity, for example, were considered amenable to surgery, as well as physical causes of ill health. By the mid-1880s, even Battey acknowledged that the operation was being performed too frequently.<sup>140</sup> It was the use of the procedure by psychiatrists in state institutions, which eventually led to it falling into disrepute. The Committee on Lunacy of the Pennsylvania State Board of Public Charities intervened when they learned that some forty to fifty operations had been planned as a supposed 'cure' for mental

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<sup>135</sup> Ibid., p.272.

<sup>136</sup> Ibid., see also, L. Tait, *The Pathology and Treatment of Diseases of the Ovary* (4th ed.) (Birmingham and New York, 1883), p.326.

<sup>137</sup> Ibid. Tait claims to have performed his first 'normal' ovariectomy in February in 1872, but did not report the case at the time. See also, Longo, 'The Rise and Fall of Battey's Operation', p.276.

<sup>138</sup> Ibid., p.274. Oophorectomy (removal of the ovary) replaced the previous term ovariectomy.

<sup>139</sup> Ibid, p.272.

<sup>140</sup> Ibid. p.273.



illness. Such procedures, they concluded, were 'brutal and inhumane (and) not excusable on any reasonable grounds'.<sup>141</sup> By the 1890s, the tide was turning and, at the turn of the century, few gynaecological textbooks even mentioned the procedure.

Nonetheless, for a number of years normal ovariectomy, or Battey's operation as it came to be known, had its firm adherents; Sims, for example, championed the procedure and used it for a wide range of conditions.<sup>142</sup> Another leading advocate of ovariectomy was Lawson Tait, although there were important differences between Battey's and Tait's approach and technique.<sup>143</sup> As Morantz-Sanchez has noted, in terms of diagnosis, Tait emphasized the importance of visible pathology and was extremely reluctant to operate for vague symptoms, such as neuralgia, or painful menstruation, although occasionally he did so.<sup>144</sup> Tait's writings on this procedure appear to confirm this. He states that he was not greatly in favour of 'Battey's operation' and thought that it should be confined to those cases in which there were 'serious symptoms so intimately associated with menstruation' as to suggest that they might be cured by establishing a 'premature menopause'.<sup>145</sup> In his own practice, Tait limited the procedure to epilepsy. He pointed out that almost every patient with epilepsy found that she was worse during her menstrual week. In some women, the epileptic fits were solely confined to the menstrual period; such cases were described as 'menstrual epilepsy'. Tait claimed that he had been sent many such cases but had operated on only five women, all of

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<sup>141</sup> 'Removal of the ovaries as a therapeutic measure in public institutions for the insane', *Journal of the American Medical Association*, 20 (1893), pp.135-37. Cited *ibid.*, p.278.

<sup>142</sup> *Ibid.*, p.275.

<sup>143</sup> Morantz-Sanchez, *Conduct Unbecoming a Woman*, p.99

<sup>144</sup> *Ibid.*

<sup>145</sup> Tait, *Diseases of the Ovary*, pp.328-29.



whom being patients where the disease had resisted other forms of treatment. He reported limited success with such operations. One girl, an imbecile from birth, was an inmate of Birmingham Borough Asylum. Now aged eighteen, she had developed 'the most violent menstrual epilepsy from the time of the molimen'.<sup>146</sup> Her condition deteriorated to such an extent that during the period she required the constant care of two attendants and the superintendent at the asylum was convinced that the disease would prove fatal. Since the operation, there was still a degree of increased noisiness at the time when her periods should occur and occasionally the young girl had an attack of *petit mal*, but menstruation was completely arrested and the violent epilepsy had disappeared.<sup>147</sup> Tait reported a similar outcome for his other cases and concluded that whilst the operation was technically straightforward and the recovery of the patient satisfactory, he was uncertain about the secondary results. He was not disposed to hamper his work in other directions to pursue this further and had suspended his present trial of the operation in such cases. As to the matter of neurasthenic cases, 'where the symptoms are all subjective and the physical signs negative', he had 'absolutely no material'.<sup>148</sup>

In part, Tait's decision to cease operating for epilepsy was due to the 'present aspect of professional opinion'.<sup>149</sup> He thought that much of the opposition to ovariectomy, both professional and public, was due to the unfortunate phrase 'normal ovariectomy'. The term suggested that that healthy ovaries were removed on 'slight or insufficient provocation, whereas, with very

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<sup>146</sup> Ibid., p.328.

<sup>147</sup> Ibid.

<sup>148</sup> Ibid., p.329.

<sup>149</sup> Ibid.

few exceptions, all the organs were diseased'.<sup>150</sup> The terms 'spaying' and the 'castration of women', were equally objectionable; further, as far as his practice was concerned, they did not properly describe the facts of the operation. In his text, Tait explains that when he removed an ovary he called the operation 'ovariotomy', and added a description of the disease, (such as ovarian cystoma), for which the operation was done. Experience had shown, however, that the removal of the fallopian tubes was more important and when he carried out this procedure he generally, but by no means always, removed the ovaries with them. He described this operation as 'removal of the uterine appendages'.<sup>151</sup> The Medical Report (1891) shows that between 1879 and 1891, 'removal of uterine appendages' (which came to known as Tait's operation) was the procedure most often performed. Of 879 abdominal operations for ovarian or uterine disease, 585 (66.5 per cent) were 'removal of uterine appendages'; 246 (27.98 per cent) removal of one ovary for cytoma; 48 (5.4 per cent) were classified as hysterectomy. The most frequent causes of disease were infection or chronic inflammation of the fallopian tubes or ovaries and ovarian cysts. Removal of appendages for hydro-salpinx (accumulation of serous fluid in the fallopian tubes), pyo-salpinx (accumulation of pus in the fallopian tubes), or chronic ovaritis (inflammation of the ovaries), accounted for almost 40 per cent of the operations. The removal of one ovary or bilateral removal of appendages for cytoma, accounted for a further 39 per cent of operations performed.<sup>152</sup>

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<sup>150</sup> Ibid., p.326.

Table 1

*The Birmingham and Midland Hospital for Women*  
*Medical Report 1891*

Abdominal Sections since 1879

Name of operation	Cases	Deaths	Mortality percentage
<b>Removal of appendages:</b>			
For hydro-salpinx	64	1	1.5
For chronic ovaritis	175	6	3.4
For myoma	144	7	4.8
Bi-lateral for cytoma	95	6	6.3
<b>Removal of one ovary</b>			
For cytoma	246	18	7.3
Removal of Appendages for Pyo-Salpinx*	107	15	12.2
Hysterectomy	48	20	41.6

\*This nomenclature does not include all cases of acute inflammatory disease of the Appendages.

The extension of ovariectomy to include other pelvic organs was widely condemned. Many leaders in the women’s medical movement were deeply opposed to such radical solutions. Elizabeth Blackwell, for example, proposed ‘to rally female physicians against the wholesale sterilization of women’.<sup>153</sup> The feminist argument was perhaps most clearly articulated in America, but in the United Kingdom opposition to ‘Tait’s operation’ was mounting. Most damning in his criticism was Spencer Wells, who dismissed the procedure as a ‘spaying’

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<sup>151</sup> Ibid., p.327.  
<sup>152</sup> BCA, BMHW, HC/WH 1/5/1, Medical Board Minutes, 1891.

operation. He implied that Tait was an 'illogically enthusiastic experimenter' and demanded that there should be 'at least some evidence of the ovaries being diseased before consenting to their extirpation in the hope of curing any of those vague disorders to which women are so subject'.<sup>154</sup> According to Wells, using Tait's criteria, few women who had a disorder that could be connected to the generative organs or function could escape 'laparotomy or something more'.<sup>155</sup> The problem for Tait was that many medical practitioners had doubts regarding his claims about the incidence of inflammatory disease. Wells claimed he never saw such cases in his practice and supposed 'they all went to Birmingham'.<sup>156</sup> Mary Dixon Jones rebuked Wells for his criticism of Tait's work. In all the cases of 'Tait's' operation, she had seen, disease had occurred more often in the tubes than the ovaries. She felt that if Spencer Wells's experience was different, that was due to lack of microscopic data. If his cases could be re-seen, and examined using the light of modern science, he would find that many cases did have diseased tubes.<sup>157</sup> The remarks of Spencer Wells reflected the wider debate over issues of clinical diagnosis in the later decades of the nineteenth century. The introduction of the microscope had allowed inflammation and degeneration of the underlying tissue to be identified and this evidence was used by Tait and others to support removal of ovaries and tubes. More conservative practitioners like Spencer Wells failed to see the relevance of laboratory science which they feared would replace clinical decision-making at

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<sup>153</sup> Morantz-Sanchez, *Conduct Unbecoming a Woman*, p.108.

<sup>154</sup> T.S. Wells, *Modern Abdominal Surgery: The Bradshaw Lecture Delivered at the Royal College of Surgeons of England. With an Appendix on the Castration of Women* (London, 1891), p.43. Cited Moscucci, *The Science of Women*, p.158.

<sup>155</sup> Ibid.

<sup>156</sup> Martin, *Lawson Tait*, p.12.

<sup>157</sup> Morantz-Sanchez, *Conduct Unbecoming a Women*, p.104.



the bedside.<sup>158</sup> In contrast, radical surgeons such as Tait and Dixon Jones embraced the use of pathological investigation and employed it in their clinical practice. Tait considered it of sufficient consequence to lay down the surgical law *'that in every case of disease in the abdomen or pelvis, in which the health is destroyed or life threatened, and in which the condition is not evidently due to malignant disease, an exploration of the cavity should be made'*.<sup>159</sup> (emphasis in the original).

Nevertheless, Wells and others were deeply concerned by the manner in which Tait justified his actions and what they considered was his over-zealous use of radical surgery.<sup>160</sup> The two surgeons had previously disagreed on a number of issues, notably over Lister's antiseptic technique, which Wells embraced.<sup>161</sup> Although Tait had some reservations about the antiseptic doctrine, he did not dismiss it out of hand. In *Diseases of Women*, Tait recognized that the introduction of germs into an open wound frequently had disastrous results. He also accepted that there may be agents or processes by which these germs could be destroyed. Antiseptic precautions must therefore be of use in hospitals, but they could only be of use 'against immediate and direct sepsis – that is poisoning of the wound at the time of operation'.<sup>162</sup> Tait argued that it was ridiculous to suppose that 'any antiseptic precaution could remove the dangers of an unhealthy atmosphere, foul wards, and an overcrowded hospital'.<sup>163</sup> However, he did acknowledge that such issues needed to be decided by empirical evidence and determined to give Lister's methods a

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<sup>158</sup> Ibid., pp.77-79.

<sup>159</sup> Tait, *Diseases of the Ovary*, p.323.

<sup>160</sup> Sewell, *'Bountiful Bodies'*, p. 304.

<sup>161</sup> Ibid., p.280.

<sup>162</sup> Tait, *Diseases of Women*, pp.168-9.

<sup>163</sup> Ibid., p.169

fair trial. Tait noted that his first fifty cases were 'marked by a high mortality', which disappeared in the second series, due to 'his increased experience and better sanitary arrangement of the patient'.<sup>164</sup> He could find no evidence that the mortality had reduced further as a result of the antiseptic system he had introduced. He compared this to Dr Keith's experience; Keith had started out with a mortality rate much lower than Spencer Wells and it had been diminishing in each succeeding 100 cases. Tait attributed this to Keith's increasing skill and care in operating and there was 'no evidence of a mortality diminished in a greater proportion that might have been expected without it'.<sup>165</sup> Tait subsequently rejected Listerism and frequently denounced its methods in the medical press.<sup>166</sup> Tait analysed statistics from around the country and compared the clinical results of antiseptics with those where the antiseptic system had not been followed.<sup>167</sup> His own mortality rate was just 3 per cent in his latest series of 100 ovariectomies, which he attributed to his careful aseptic method.<sup>168</sup> In his text, Tait cautioned surgeons about the use of Lister's system, suggesting that the antiseptic spray impeded the operator's vision. More than once, he noted, he had seen an ardent antisepticist get into difficulties at operation, as a result of this.<sup>169</sup>

Tait's attacks on such respected figures such as Lister and Wells made him extremely unpopular within the medical establishment and the conflict was to come to a head over the 'Imlach affair'. Francis Imlach was a young provincial

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<sup>164</sup> Ibid.

<sup>165</sup> Ibid.

<sup>166</sup> *British Medical Journal* (hereafter, BMJ), Vol.1 (1886), p.923 and Vol. 2,(1884), pp. 258-60. Cited Sewell, 'Bountiful Bodies', p.293.

<sup>167</sup> Lawson Tait, 'Clinical Lecture on the Details Necessary in the Performance of Abdominal Section'.

<sup>168</sup> Lawson Tait, 'One Hundred Consecutive Cases of Ovariectomy, performed without any of the Listerian details', *BMJ*. Vol.2 (1882), pp. 830-832. Cited Sewell, 'Bountiful Bodies', p.294.

<sup>169</sup> Tait, *Diseases of Women*, pp.169-70.

surgeon, forward thinking and eager to take advantage of the new developments in abdominal surgery. Imlach was evidently deeply influenced by Tait. In a paper that he presented to the Liverpool Medical Institution in 1885, he detailed forty-one operations in which he had removed the ovaries and tubes for pyosalpinx, hydrosalpinx or haematosalpinx (accumulation of blood in the fallopian tubes). As Moscucci has noted, 'Imlach had only three deaths, but his colleagues were not impressed'.<sup>170</sup> The senior surgeon, Thomas Grimsdale and John Wallace, Professor of Midwifery condemned the procedure as 'unsexing women' and the vast majority of their colleagues agreed.<sup>171</sup> An audit of the gynaecological surgery undertaken at the hospital between 1884 and 1885 revealed that nearly half of all patients admitted had undergone abdominal operations. Of these, 64 per cent had had ovaries and tubes removed; it transpired that Imlach had performed 80 per cent of such operations. Furthermore, he had done so without previously consulting with his colleagues, as the hospital regulations required.<sup>172</sup> Initially co-operative, Imlach later refused to observe the rule, claiming that his colleagues were deliberately obstructive:

The persons you are supposed to consult with may be radically prejudiced against the operation, or they may have too little confidence in their own judgement and experience to give a decisive decision. In such a case, I

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<sup>170</sup> Moscucci, *The Science of Woman*, pp.161-62.

<sup>171</sup> Ibid.

<sup>172</sup> 'An Interview with Dr.Imlach', *Liverpool Review*, 18 December, 1886, p.5. Cited M. Royden, 'Caring for Women and Babies in Liverpool. A History of Liverpool Maternity Hospital and the Women's Hospital', unpublished paper to celebrate 150 years of obstetric and gynaecological services (copy held at Liverpool Public Library).



either had to defer to prejudice or hostility and let the patient die, or save her at my own risk, and I chose the latter course.<sup>173</sup>

In February 1866, it was claimed by a local doctor that Imlach had 'unsexed' a woman by removing her ovaries on the supposition that she was suffering from ovarian disease. Imlach denied charges of over-operating and claimed the ovaries he removed were diseased. Immediately, Grimsdale proposed an inquiry into the 'grave question of practice and ethics of these operations at the Women's Hospital'.<sup>174</sup> Publication of the Report of the Inquiry was delayed by a civil action by a patient, Mrs Casey. It was claimed that Imlach had removed the patient's ovaries and fallopian tubes inappropriately, without prior consultation with his colleagues or the patient's consent. Wells and Grimsdale appeared for the plaintiff. In evidence, Grimsdale stated that 'Mrs Casey's condition did not justify an operation. He had many cases like that and most of them recovered with medical treatment and prolonged bedrest.'<sup>175</sup> Imlach counted some of the leading gynaecologists among his supporters; Tait, James Aveling and Thomas Savage being among those who defended Imlach. Tait used the occasion to engage in a debate over the use of 'normal' ovariectomy. He accused Wells of being out of date; what Wells called 'spaying', Tait called the removal of the uterine appendages; where Wells perceived health, Tait diagnosed pathology.<sup>176</sup> Imlach was subsequently found not guilty, but the case had attracted a good deal of publicity and he was not re-elected to his post as Honorary Surgeon at the annual meeting in January 1877.<sup>177</sup> Imlach's career was effectively ruined by the Inquiry of 1866, and the rift between Tait

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<sup>173</sup> Ibid.

<sup>174</sup> Moscucci, *The Science of Woman*, p.161.

<sup>175</sup> Ibid.

<sup>176</sup> *Lancet*, 21 August 1886, pp.375-76.



and the establishment deepened. However, the Imlach case did nothing to halt the further development of gynaecological surgery.

As we have seen, by the late 1880s, mortality rates for many gynaecological procedures had improved, due to the greater experience of the surgeons and the introduction of antiseptic/aseptic techniques. Nevertheless, mortality rates for myomectomy (removal of fibroids) remained high. At the Women's Hospital, between 1879 and 1891, this procedure was performed on 48 women, with 20 deaths (a mortality rate of 41.6 per cent).<sup>178</sup> The medical report notes that they had 'given up' the procedure, as this mortality percentage was considered unacceptable. Their more recent practice, in cases of haemorrhage associated with fibroid tumours of the uterus, was to remove the uterine appendages.<sup>179</sup> As Tait explains in his text, this procedure offered the most satisfactory solution. For small tumours it offered an alternative to enucleation, it was far safer, with the added advantage that it provided security against a return of the disease. For large tumours, it was an alternative to hysterectomy: 'in the great majority of cases, it arrests the haemorrhage and the growth of the tumor at once'. Furthermore, it was 'much less fatal'.<sup>180</sup> Tait described such an operation in a paper delivered to the Royal Medical and Chirurgical Society in October 1874. The patient, a young woman of 34 years, had been suffering from a large abdominal tumour for five years; there was a history of 'profuse menstruation and frequent symptoms of pressure on the pelvic organs'.<sup>181</sup> The

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<sup>177</sup> Royden, 'Caring for Women and Babies in Liverpool', p.39.

<sup>178</sup> BCA, BMHW, HC/WH 1/5/1, Medical Report, 1891.

<sup>179</sup> *Ibid.*, The average mortality rate for removal of appendages for myoma (fibroid) was 4.8 per cent.

<sup>180</sup> Tait, *Diseases of the Ovaries*, p.329.

<sup>181</sup> *Lancet*, 31 October 1874, p.625.

fibroid, which weighed eleven pounds, was removed by an operation and recovery was reported to have been rapid and uninterrupted.<sup>182</sup>

The mortality rates reported above were not unusual however; Morantz-Sanchez has noted the stubborn persistence of high mortality rates for myomectomy throughout the 1880s. The greatest concern was severe haemorrhage, due to the vascularity of the fibroid tumours and the cervical stump.<sup>183</sup> Nonetheless, many practitioners believed that a fibroid tumour could become malignant, which would require the eventual removal of the uterus. Thereby, hysterectomy was the optimum procedure. In an effort to improve their technique, surgeons experimented with different methods of tying the cervical stump and various types of clamps, to reduce the risk of bleeding. Tait reports that when he used the method of tying the ligature recommended by Mr Spencer Wells, 'the stump shrank in a few hours from the escape of serum, the ligature loosened, and the patient died of haemorrhage'.<sup>184</sup> Equally, he was not in favour of the caliper-clamp used by Wells, as it failed to close the abdominal wound accurately. He therefore devised a circular wire clamp, which had 'proved completely successful in every case to which I had applied it'.<sup>185</sup> Tait lists eight cases of hysterectomy for myoma in which the circular wire clamp was used. Three patients were treated in hospital; the remaining five patients were private. All patients had recovered.<sup>186</sup> Tait anticipated that, now he had resolved the problem of dealing with the pedicle, he would do 'almost as well in the removal of uterine tumors as I have done in ovariectomy'.<sup>187</sup> While this

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<sup>182</sup> Ibid.

<sup>183</sup> Morantz-Sanchez, *Conduct Unbecoming of a Woman*, pp.100-01.

<sup>184</sup> Tait, *Diseases of the Ovaries*, p.334.

<sup>185</sup> Ibid., p.335.

<sup>186</sup> Ibid.

<sup>187</sup> Ibid., p.334.

observation is typical of Tait's boastful style, it would appear that there were some grounds for self-congratulation. The date of surgery is given for each of the eight patients mentioned above; the first case was in September 1880, one case in 1881 and the remaining six cases in 1882. Morantz-Sanchez has described Tait's (and Hegar's, in Germany) early success with fibroid tumours of the uterus as, 'actually quite remarkable'.<sup>188</sup>

As methods to reduce the various problems associated with abdominal surgery were identified, attention was turned to their utility in other surgical procedures. Certainly, there is evidence of Tait's growing interest in general surgery. Although his primary concern at the hospital was gynaecology, Tait's conviction in the value of abdominal exploration made it inevitable that he would meet disease in other organs. As Shepherd has observed, until the mid-1870s, few abdominal procedures were undertaken, other than for ovarian cysts. Thus, there were no established techniques for diseases of the digestive organs, biliary or renal systems.<sup>189</sup> The statistical tables for 1882 denote that Tait performed surgery on the liver, kidney and gall bladder at the hospital.<sup>190</sup> This was not his first encounter with surgery of the biliary tract. In 1879, Tait was consulted by a woman with a large painful swelling on the right side of the abdomen. Undertaking an exploratory operation, he discovered a large gallstone, which he removed, and a further large stone impacted in the cystic duct. Thereupon, he 'performed a very careful and protracted lithotrity, chipping little fragments off the stone regularly all over until I had the satisfaction of lifting it out of its nucleus, I then passed a blade of a fine pair of forceps on each side of it, and by a gentle squeeze broke up the remainder and

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<sup>188</sup> Morantz-Sanchez, *Conduct Unbecoming a Woman*, p.100.



was then enabled to lift it out'.<sup>191</sup> Dr Bobbs is recorded as performing a similar successful case in Indiana in 1867, but this was the first cholecystotomy in Europe.<sup>192</sup> Tait has been credited with establishing cholecystotomy as a routine procedure and, over the next five years, he recorded fourteen cholecystotomies, with only one death.<sup>193</sup> The first elective removal of an inflamed appendix, in 1880, has also been attributed to Tait.<sup>194</sup> Lawson Tait received international recognition for his work in the development of surgery of the biliary tract. An American surgeon wrote 'To Tait, more than any other surgeon of this period, is due the credit of placing the surgery of the liver and the gall bladder on a firm basis.'<sup>195</sup>

Tait never received the same degree of professional acknowledgement in the UK. The Imlach affair and the Wells-Tait conflict soured relations with many within the medical elite and his later years were spent in professional isolation. A libel action brought by Dr Denholm precipitated his final downfall. Denholm had referred a patient with a uterine tumour, who had previously been treated with a course of intra-uterine electricity, which had resulted in a vesico-vaginal fistula. Tait performed a hysterectomy for myoma but the patient had a post-operative haemorrhage, and died forty-eight hours after surgery. Angered at what he considered was an unnecessary loss of life, Tait wrote to the husband, blaming his wife's death on the previous electrical treatment. In the subsequent libel action neither side won; Denholme dropped the charges, but Tait's reputation was damaged by his insensitive treatment of the widower and his

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<sup>189</sup> Shepherd, *The Rebellious Surgeon*, p.62.

<sup>190</sup> BCA, BMHW, HC/WH 1/10/2, Statistical Table IV, Annual Report 1882.

<sup>191</sup> Cited Shepherd, *The Rebellious Surgeon*, p. 64.

<sup>192</sup> *Ibid.*, pp.64-65.

<sup>193</sup> Martin, 'Lawson Tait', p.10.

<sup>194</sup> Shepherd, *The Rebellious Surgeon*, p.68.



lack of regard for professional ethics.<sup>196</sup> Around the same time, Tait faced a charge that he had seduced one of his nurses, and fathered an illegitimate child. Tait strongly denied the accusation and alleged it was an attempt to blackmail him. He declared that he would have 'spent his last shilling and my wife would have sold her wedding ring, before I would have been bled in such a way'.<sup>197</sup> The charge was subsequently withdrawn after two years of legal wrangling but the episode did enormous damage to Tait's professional and personal reputation and he was forced to retire from active practice in 1893, and live on much reduced financial means.<sup>198</sup> He continued to write for the medical and lay press and it is clear that he kept abreast of professional issues. His last important article, 'The Treatment of Unavoidable Haemorrhage by Removal of the Uterus' in which he anticipated the practice of caesarean section in these cases, was published on 11 February 1899.<sup>199</sup> Lawson Tait died on 13 June 1899, at his home in Llandudno, at the early age of 54 years. On 14 June, *The Times* printed a brief announcement of his death, noting that 'he brought into existence a large number of new operations for diseases of the abdomen and perfected many others'.<sup>200</sup>

In conclusion, Tait was perhaps the most dynamic and intriguing of all those who helped to establish and promote the Women's Hospital. His technical skills as a surgeon undoubtedly earned this small, provincial institution the international reputation it acquired. For this achievement alone, Tait has earned a lasting place in the annals of the hospital; however, it would be wrong

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<sup>195</sup> Ibid., p.63.

<sup>196</sup> Sewell, 'Bountiful Bodies', pp.259-60, Martin, 'Lawson Tait', p.15.

<sup>197</sup> Shepherd, *The Rebellious Surgeon*, p.176.

<sup>198</sup> Martin, *Lawson Tait*, p.16.

<sup>199</sup> Ibid.

<sup>200</sup> *The Times*, 14 June 1899.

to suggest that he did not have influence in other spheres. As we have seen, Tait was a powerful advocate of women in medicine and a useful ally to support Chamberlain in furthering this cause. This is not to imply that the two men always saw eye-to-eye; as Arthur Chamberlain noted 'on matters of detail they did often differ very strongly' and discussed these matters openly at the Annual Meeting.<sup>201</sup> There is also a suggestion of some coolness between Tait and Thomas Savage. Reminiscing to members of staff in the late 1950s, the daughter of Dr Savage is reported as saying that her father and Tait did not meet much socially, adding 'My father was a gentleman'.<sup>202</sup> This does not appear to have affected their professional relationship. Tait and Savage were on equal terms at the hospital and they appear to have worked well together. They adopted very similar methods and the statistical records show that Savage achieved much the same results. In truth, there is nothing in the contemporary accounts to suggest serious quarrels amongst the staff, which is quite exceptional when we consider that Tait had a reputation for quarrelling with anyone. It is possible that, like many within the medical world, they respected Tait for his surgical skill, although they had reservations regarding some aspects of his character.

Some thirty years after his death, this hostility was still evident. Sir Gilbert Barling (then Pro-Chancellor of Birmingham University), recalled that Tait was 'a fine surgeon with an enquiring mind, bold, dextrous, and with a remarkable capacity for getting out of difficulties when they arose'.<sup>203</sup> He acknowledged that 'To him are due many of the great advances in abdominal surgery which I

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<sup>201</sup> BCA, BMHW, HC/WH 1/10/4, Annual Report, April 1900.

<sup>202</sup> Gough, 'The Birmingham and Midland Hospital for Women', p.3.

<sup>203</sup> G. Barling, 'Some Reminiscences of Lawson Tait', *Birmingham Medical Review* (June, 1931), p.137

have seen in the last fifty years.'<sup>204</sup> Nonetheless, Barling qualified this praise, noting that 'against these qualities, others must be recorded'.<sup>205</sup> He questioned Tait's method of compiling statistics, suggesting that he grouped the cases to present them in the most favourable light and described Tait's attitude to Lister and his methods as 'very curious'.<sup>206</sup> As Barling observed, Tait had 'too acute a mind not to recognize the great principle laid down by Lister'.<sup>207</sup> Yet, he recalled that, at a major conference on antiseptic surgery, Tait 'scouted' Lister's work. His motive, Barling believed, was to deliberately and wilfully, try to discredit Lister'.<sup>208</sup> Barling concluded that Tait ought to have been regarded as 'one of the great surgeons of the world. The one thing he lacked was what we call character with a large "C"'.<sup>209</sup>

Nonetheless, it was perhaps those qualities that most alienated his colleagues, his forceful personality and his determination to overcome opposition to what he regarded as progress, that allowed Tait to play his part in the development of abdominal surgery. As we have seen, this was a period of fierce dispute within the medical profession; the development of cellular pathology and the role of the microscope were matters of contention between 'old-school' and second generation ovariologists. Arguments on these matters occurred on both side of the Atlantic but, as evidenced by the 'Imlach affair' and the attacks on Tait, they were of a more personal nature in the UK. Undoubtedly, Tait's ability to argue with anyone often raised unnecessary opposition and hostility but the final words, on so complex a character surely

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<sup>204</sup> Ibid.

<sup>205</sup> Ibid.

<sup>206</sup> Ibid.

<sup>207</sup> Ibid.

<sup>208</sup> Ibid.

<sup>209</sup> Ibid.

belong to the man who knew him best. Speaking at the Annual Meeting, Arthur Chamberlain spoke these words in tribute:

Mr Lawson Tait was a man of so excellent a disposition, of so kind a heart, and of so frank and generous a nature, that he was a man with whom one could argue without quarrelling, and from whom one could differ without rancour ... Whatever differences he had with Mr Lawson Tait upon matters of detail, he ought to say that Mr Tait followed his principles to the uttermost, and having satisfied himself that he had got hold of the right principle, he would support it, without considering what difficulties it might cause him, or caring very much with whom it brought him into conflict. What he wanted was to get at the truth, and in his bold and honest way he did succeed more often than was permitted to by most of them to finally reach correct conclusions and to carry them into practice.<sup>210</sup>

Tait was perhaps 'a man for his time', for it is by no means certain that a less forceful character would have achieved as much.

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<sup>210</sup> BCA, BMHW, HC/WH 1/10/4, Annual Report, April 1902.



## Chapter 4

### *Nurses, Wives and Mothers*

#### *Patients and their Care c.1871-1905.*

The competing paradigms in the historiography of women's health have been considered in the introduction to this thesis. Of particular interest, in the context of voluntary hospitals, is the argument that much of the feminist scholarship obscures the different experience of health and disease across social class.<sup>1</sup> This is not to suggest that middle-class women did not suffer sickness and pain; historically, class has offered little protection from suffering. Notwithstanding home confinements and private medical care, Margaret Gladstone died from puerperal fever in 1870.<sup>2</sup> Even greater sorrow was to befall Joseph Chamberlain; his first wife Harriet died just two years after their marriage, following the birth of their second child. Chamberlain remarried his first wife's cousin, Florence Kenrick, but a second blow was to befall. Florence died just eighteen hours after childbirth, in 1875.<sup>3</sup> Conversely, working-class women suffered minor illnesses and 'nervous complaints', such as headaches, lassitude, general irritability and loss of self-control, possibly as frequently as their middle-class sisters. In the early 1900s, one working-class mother described her despair after the death of her second child thus: 'My interest in life was lost. I was nervous and hysterical; when walking along the streets I felt that the houses were falling in on me.'<sup>4</sup> Clearly, this woman's mental breakdown was not the result of her attempts to

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<sup>1</sup> O. Moscucci, *The Science of Women. Gynaecology and Gender in England 1800-1929* (Cambridge, 1990), pp. 4-5.

<sup>2</sup> P. Jalland, *Women, Marriage and Politics, 1860-1914* (Oxford, 1986), p.135.

<sup>3</sup> J. L. Garvin, *The Life of Joseph Chamberlain, Volume 1, 1836-1885* (London, 1932), pp.77ff

compete with men academically, or seeking other alternatives to her maternal duties, held to be the cause of female insanity by many Darwinian psychiatrists.<sup>5</sup> According to Thomas Clouston, physician superintendent at the Royal Edinburgh Asylum, such signs of mental illness were frequently seen in working-class women. He attributed this phenomenon to the difficult and sometimes intolerable circumstances of their lives.<sup>6</sup> Despite her obvious distress, the bereaved young mother was not referred to a 'nerve specialist' or confined to an asylum for the insane, as was the experience of many well-to-do and intellectual women at the time.<sup>7</sup> Unable to afford a doctor, this unfortunate woman 'took to staying at home, which of course made matters worse'.<sup>8</sup> Thus, as Anne Digby has observed, 'gender dictated common situations for women, but their social class differentiated the treatment they received'.<sup>9</sup>

As Clouston noted, the social circumstances of working-class women in the late nineteenth and early twentieth centuries were very different to those experienced by middle-class women.<sup>10</sup> The multiplicity of roles that working-class women had to fulfil, as 'nurse, wife, mother and domestic manager', combined with the 'ongoing stress of poverty',<sup>11</sup> and all the hardships that implied, inevitably lead to physical ailments. Those historians who have

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<sup>4</sup> M. Llewelyn Davies, *Maternity. Letters from Working-Women Collected by The Women's Co-operative Guild* (1915) (republished, London, 1978).

<sup>5</sup> E. Showalter, *The Female Malady. Women, Madness and English Culture, 1830-1980* (London, 1987), p.123.

<sup>6</sup> T. Clouston, *Clinical Lectures on Mental Diseases* (London, 1883), pp.13-14. Cited E. Thompson, 'Women in Medicine in the Late Nineteenth and Early Twentieth Century Edinburgh: A Case Study', PhD thesis, University of Edinburgh, 1988, p.170.

<sup>7</sup> Showalter, *The Female Malady*, p.135.

<sup>8</sup> Davies, *Maternity*, p.24.

<sup>9</sup> A. Digby, *Making a Medical Living. Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge, 1994), p.278.

<sup>10</sup> Clouston, *Clinical Lectures*, pp. 510-13. Cited Thomson, 'Women in Medicine', p.170.

<sup>11</sup> *Ibid.*

researched women's health within the voluntary hospital system have uncovered a significant degree of ill health, much of which was of a physical, rather than psychosomatic or 'nervous' nature. Edward Shorter, for example, has shown that the number of women treated for minor illnesses or 'nervous disorders' at the Mt. Sinai Hospital, New York, was negligible, compared to those treated for pelvic infection or birth induced trauma.<sup>12</sup> A similar pattern may be found in voluntary hospitals in Britain; much of the early surgery performed at the Sheffield Hospital for Women was performed to repair problems caused by too frequent pregnancies, or the mismanagement of obstetric care.<sup>13</sup>

We learnt, in the previous chapter, of some of the medical conditions treated at the Women's Hospital, but medical care was just one part of the patient's experience. The hospital environment, the ward regime and nursing care all contribute to a positive medical outcome and profoundly influence the patient's perception of her care. Caring is often portrayed as the essential feature of nursing but nurses require a range of more tangible skills. As will be shown below, it was the practical nature of nursing, with its emphasis on technical tasks and physical skills that underpinned the Nightingale model of nursing used at the hospital. The thought given to planning her care after discharge from hospital also affected the woman's long-term recovery. Thus, the care of the patient following the period of admission, such as arrangements made for continuing care and convalescence will also be considered in this chapter. As discussed in Chapter Two, it was claimed that

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<sup>12</sup> E. Shorter, *Women's Bodies. A Social History of Women's Encounter with Health, Ill-Health and Medicine* (New Jersey and London, 1991), pp.277-79.

<sup>13</sup> H. Mathers and T. McIntosh, *Born in Sheffield. A History of Women's Health Services 1864-2000* (Barnsley, 2000), pp.33-34.



hospitals, staffed by female practitioners, were more appropriate for women than those staffed by male doctors, as their holistic approach was more in tune with women's sensitivities. One aim of this chapter is to consider how far the gender of the practitioner influenced the medical treatment and care of women. For this purpose, a short comparative study will be made between the therapeutic approaches at the Women's Hospital and Jex-Blakes's Edinburgh Hospital for Women and Children. The primary object of this chapter is, with the aid of administrative and patient records, to build a picture of the women who sought care at the Women's Hospital in Birmingham.

As with many voluntary hospitals in the city, much of the archival material from the Women's Hospital has survived. The in-patient registers are complete from 1871-1905, then periodically between 1905 and 1927. These record the patient's diagnosis, her age, marital status and occupation of the woman and her husband, or father. Such information can establish a profile of the patients, and provide an overview of the spectrum of diseases women suffered from. Also helpful is the statistical information, contained in the Annual Reports, which reveal patterns of clinical activity. For the purpose of this chapter, I have undertaken a sampling of the registers, selecting fifty consecutive cases, at five yearly intervals over a period of twenty-five years. As Ortrun Riha has noted, there are advantages to be gained from this method. The detailed analysis of a relatively small number of files may reveal a number of interesting observations that may be missed in electronic summaries of hundreds of records.<sup>14</sup>

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<sup>14</sup> O. Riha, 'Documents and Sources. Surgical Case Records as an Historical Source: Limits and Perspectives', *Social History of Medicine*, 8 (1995), pp. 279-80.



To gain an understanding of the patient, hospital records need to be supplemented by a wider consideration of the social, economic and cultural forces that shaped women's lives. As noted above, the patient registers contain only limited information; furthermore, the administrative records contained little detail concerning the social circumstances of the patients. Contemporary accounts, such as the oral histories collected by Elizabeth Roberts and the letters sent in response to an appeal by Margaret Llewellyn Davies in 1914, provide some insight into poorer women's health concerns.<sup>15</sup> The object of the appeal was to provide evidence of women's experiences of pregnancy and childbirth in support of the scheme 'to improve the virtually non-existent maternal and infant care then available to the poorer woman'.<sup>16</sup> Of the 386 replies received, 160 letters were published as *Maternity. Letters from Working-Women Collected by the Women's Co-operative Guild*, in 1915. The poverty, toil, and the indifferent obstetric care the women reported have been confirmed by other contemporary surveys.<sup>17</sup> Thus, the letters had been seen as representing the views of 'the voteless and voiceless millions of married working-women of England'.<sup>18</sup> This unique record of women's own account of their lives broadens our understanding of the problems they encountered in their daily lives and how these may have contributed to their ill-health.

We have some knowledge of the range of diseases that women in Birmingham suffered from, as the medical staff documented the diagnosis of

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<sup>15</sup> E. Roberts, *A Woman's Place. An Oral History of Working-class Women 1890-1940* (Oxford 1984) (reprinted in paperback, 1996), Davies, *Maternity*.

<sup>16</sup> *Ibid.*, New introduction by Gloden Dallas, p.1.

<sup>17</sup> J. Lewis, *Women in England 1870-1950. Social Divisions and Social Change* (London, 1984), E. Ross, *Love and Toil: Motherhood in Outcast London, 1870-1918* (Oxford, 1993), Roberts, *A Woman's Place*.

all patients who attended the out-patient department in the first weeks and months after it opened in October 1871.<sup>19</sup> The medical report shows that around 19.4 per cent of women presented with disorders of menstruation.<sup>20</sup> These cannot be dismissed as trivial complaints, as menstrual symptoms are often a sign of underlying disease. For example, amenorrhoea (absence of menstruation) has a number of causes among which are tuberculosis and profound anaemia, unlikely to be found today, but far more common among the working classes in the nineteenth century. Similarly, menorrhagia (heavy menstrual loss) is a symptom that may indicate the presence of fibroids or pelvic infection. Pelvic inflammatory disease, or infection of the external genital organs, was the primary diagnosis in 18 per cent of patients.<sup>21</sup> As noted in the previous chapter, Lawson Tait held that venereal disease was the source of much pelvic infection. Other possible causal factors are tuberculosis and acute infections, perhaps initially introduced during childbirth, which remained unresolved and subsequently led to chronic disease. Further causes of ill health were tumours, cysts, fibroids, and other conditions symptomatic of carcinoma; which cumulatively accounted for 13.3 per cent of patient attendances.<sup>22</sup> However, the largest group, around 21.5 per cent of patients, were suffering the long-term effects of childbirth, with prolapsed or displaced uteri, or ruptured or torn perineum.<sup>23</sup>

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<sup>18</sup> Davies, *Maternity*, p.1.

<sup>19</sup> Birmingham City Archives (hereafter, BCA), Archives of The Birmingham and Midland Hospital for Women (hereafter, BMHW), WH/HC 1/5/1 Medical Board, March 1872.

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

<sup>23</sup> Ibid.

Table 2

*The Birmingham and Midland Hospital for Women*  
*Medical Board Minutes March 1872*

Out-patient attendance between October 1871 and February 1872 by diagnostic group

Group 1: Prolapse, displacements of uterus and perineal lacerations:	131
Group 2: Disorders of menstruation:	118
Group 3: Infection of the reproductive organs or pelvis:	109
Group 4: Tumours, cysts and fibroids:	52
Group 5: Climacteric derangement, hysteria and menstrual epilepsy:	36
Group 6: Conditions diagnosed or symptomatic of carcinoma*:	29
Group 7: Pregnancy, complications of pregnancy and abortion:	13
Group 8: Anaemia:	11
Group 9: Miscellaneous gynaecological conditions:	13
Group 10: Miscellaneous conditions, non-gynaecological:	72

The non-gynaecological cases are likely to be among those considered not to be within the province of the hospital and referred elsewhere.

\*For example, ulceration of the cervical Os, (20 cases) is a cardinal sign of carcinoma of the cervix.

This would accord with the evidence presented in the *Maternity* letters. Llewelyn Davies estimated that around two-thirds of the women had experienced complications of pregnancy.<sup>24</sup> Many of these were minor complaints; of greater concern to the mothers were the often long and difficult labours. Such births frequently resulted in injury to the mother; a common condition was ‘falling of the womb’ (prolapsed uteri), caused by ‘hours of suffering’; one woman reported that she was still suffering some thirty years

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<sup>24</sup> Davies, *Maternity*, p.192.

later.<sup>25</sup> The problem identified was the level of care available to the poorer woman. Although obstetric care had reached a reasonable standard in some areas by the latter decades of the nineteenth century (for example, the maternal mortality rate for Birmingham Lying-in Charity in 1871 was 1:246 against the average for large towns of 1:204),<sup>26</sup> maternity services were piecemeal and the type of care was largely dependent on the amount the mother could afford to pay. Usually the birth would take place at home, attended by a doctor, if the mother could afford it and a midwife, but more often by a midwife alone.

As Irvine Loudon has pointed out, the term midwife does not denote a homogeneous group; it has been used to describe 'trained and untrained midwives, monthly nurses and handywomen'.<sup>27</sup> In the context of this chapter, it is important to establish what is meant by the term 'trained midwife'. For much of our period, the vast majority of midwives had no formal training for their work. Midwifery experience was acquired through an informal apprenticeship, often with a mother or other family member, or by attending neighbourhood births with an established midwife. Following Loudon, I have confined the term 'trained midwife' in this thesis to those who have had a formal training.<sup>28</sup> Notwithstanding this distinction, doubtless many untrained midwives were able and acquired expertise through practise. Furthermore, they were of the same social class and usually lived in the same

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<sup>25</sup> Ibid., pp.28-29.

<sup>26</sup> For example, in 1871, the maternal mortality rate for Birmingham Lying-in Charity was one in 246. According to Florence Nightingale, the average maternal mortality in large towns was 4.9 per 1000, or one in 204. *Birmingham Post*, 24 November 1871.

<sup>27</sup> I. Loudon, 'Midwives and the Quality of Maternal Care', in H. Marland and A.M. Rafferty (eds), *Midwives, Society and Childbirth. Debates and Controversies in the Modern Period* (London and New York, 1997), p.181.

<sup>28</sup> Ibid., pp.181-82.



neighbourhood; thus, the mother could relax in the knowledge that the midwife would not be critical of the crowded living conditions and less than spotless sheets. As Jane Lewis has noted, such practitioners were highly valued by working-class women as many 'handywomen' both delivered the baby and looked after the family during the lying-in period.<sup>29</sup> This type of care was quite acceptable for routine births; nonetheless, few midwives were equipped to deal with obstetric complications. One mother recalls a long and difficult labour attended by a midwife, from which she never recovered.<sup>30</sup> This is not to suggest that a doctor was always preferred; as evidenced by the letters from other Guild members, neither category necessarily provided any guarantee of competence. Certainly, careless practice could be dangerous. The Birmingham correspondent of the *Lancet* reported an inquest on a woman who had died of puerperal fever in October 1874; it was disclosed that the same surgeon and midwife had attended five or six fatal cases, all within the period of one month. The jury returned a verdict to the effect that the deceased had died of puerperal fever and recommended that 'there should be some positive legislation regulating the precautions necessary in the case of a midwife or a medical man attending midwifery cases after having been in contact with a case of puerperal fever, and they request that a copy of the evidence and this recommendation be forwarded to the Secretary of State'.<sup>31</sup>

Evidently, both midwife and doctor were culpable in this case. Nevertheless, contemporary observers recognized that Britain was way behind the Continent in the standard of its midwives, a point that Loudon has

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<sup>29</sup> J. Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939* (London and Montreal, 1980), p.20.

<sup>30</sup> Davies, *Maternity*, p.115.

<sup>31</sup> *Lancet*, 31 October 1874, p.642.

also made.<sup>32</sup> Lawson Tait was one of those doctors who recognized the need for formal training. In his article on 'The Medical Education of Women' (1874), Tait estimated that at least one third of the births in England were superintended by midwives, largely because the midwife system was encouraged to prevent cross infection. He observed that parturient women were peculiarly susceptible to septic influences and it was considered much safer if their labours were superintended by a midwife who did not attend to cases of the other diseases commonly found in general practice.<sup>33</sup> Tait suggested that there was an increasing demand for 'a class of practitioner competent to superintend the ordinary run of obstetric cases'.<sup>34</sup> He acknowledged that midwives were most likely to undertake that kind of work, but maintained that the present system of midwifery needed developing and regulating. Tait insisted that it was imperative that 'midwives be taught the process of normal parturition thoroughly, and enough of obstetric science to let them know when *operative* assistance is required, or how to act in an emergency'.<sup>35</sup> In support of his argument, Tait described the system of midwifery training at the Medical School of the University of Marburg, in Prussia. During her course of instruction, which was often part-funded by the community from which she was sent, the midwife was required to attend a series of lectures. Clinical experience was gained under the supervision of the professor of midwifery, or his assistant, and the midwife had to write clinical reports of her cases. At the end of her six-month course, she was examined by a state assessor and, if successful, received a government

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<sup>32</sup> *Birmingham Post*, 'Birmingham Lying-In Charity, Annual Meeting', 24 November 1871. See also Loudon, 'Midwives', p.180.

<sup>33</sup> L. Tait, 'The Medical Education of Women', *Birmingham Medical Review*, 3 (1874), p.91.

<sup>34</sup> *Ibid.*

certificate of competency. Throughout their practice, midwives were inspected every third year; reports being made of their conduct and character.<sup>36</sup> Tait recommended such a system could usefully be adopted in England.<sup>37</sup>

Tait's proposals would appear to have anticipated the demands of the Co-operative Guild's scheme for maternity care, which called for the local supervision of midwives and 'such assistance as may be needed to ensure the mother having skilled and prompt attention during confinement at home'.<sup>38</sup> They also demanded admission to hospital for mothers with complications of pregnancy or labour and improved ante-natal and post-natal care.<sup>39</sup> That such a campaign was necessary is perhaps surprising, given the government's concern over the falling birth rate and 'national deterioration'.<sup>40</sup> Certainly, governments took action to reduce the infant and maternal mortality rates but little attention was paid to broader aspects of infant and maternal welfare, such as poor living conditions, poor nutrition and overwork.<sup>41</sup> Few women had the means to ensure their own good health. Poverty and frequent childbirth between them brought distress, hardship and suffering. One Guild member, a mother of eleven children, described managing on her husband's wage of just £1 per week. After paying 'the house, rent, firing and light and clubs' she had just 11s to 'keep the house going'. Like many wives this

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<sup>35</sup> Ibid., p.92.

<sup>36</sup> Ibid., p. 93.

<sup>37</sup> Ibid., pp. 93-94. Tait offers a critique of medical education and licensing of the profession. He argued that it was the duty of the government to remodel entirely the method of medical licensing and to include a scheme for the licensing of midwives.

<sup>38</sup> Davies, *Maternity*, p.192.

<sup>39</sup> Ibid., pp.192-93.

<sup>40</sup> See D. Dwork, *War is Good for Babies and Other Young Children. A History of the Infant and Child Welfare Movement In England 1898-1918* (London, 1987), for a comprehensive discussion of the debates around national deterioration and infant welfare.

<sup>41</sup> Lewis, *The Politics of Motherhood*, p.27.



woman, instead of getting proper nourishment herself, was 'obliged to go without'.<sup>42</sup> The usual hierarchical order was husband first, children next and mother last.

This is not to suggest that there was widespread mistreatment of women. Elizabeth Roberts has noted that there was little feeling among the working-class women in Lancashire she interviewed that they had been particularly exploited, at least, not by working-class men.<sup>43</sup> They tended to blame the poverty and limited opportunities available to them on the employers, the rich and the middle classes, male or female and were likely to see their menfolk equally oppressed.<sup>44</sup> Thus, as Olive Banks has argued, 'working-class women had their own sources of discontent, and by and large these to be less a result of their sex than their class'.<sup>45</sup> The letters in *Maternity* appear to support Banks' thesis. There is little evidence that husbands condoned, or were even aware that their wives 'went without'. The author of letter 128 describes how she often went short of food 'although my husband did not know it. He used to think that my appetite was bad and that I could not eat. He gave me all he could.'<sup>46</sup> The reasoning behind this equation was stark; the husband needed sufficient food to enable him to work. The same principle appeared to apply to their health. Medical advice would be sought for a man, as the family could not afford to lose his wage during periods of sickness; however, few women consulted a doctor regarding their own health. Many minor problems reported in *Maternity*, such as toothache, excessive vomiting,

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<sup>42</sup> Davies, *Maternity*, pp.18-20.

<sup>43</sup> Roberts, *A Woman's Place*, p.2.

<sup>44</sup> Ibid.

<sup>45</sup> O. Banks, *Faces of Feminism. A Study of Feminism as a Social Movement* (London, 1981) (reprinted in paperback, 1986), p.5.

<sup>46</sup> Davies, *Maternity*, pp.158-59.



constipation and 'swollen legs' could have been avoided with routine ante-natal care and, notwithstanding their poverty, advice on diet may have prevented the widespread malnutrition amongst pregnant women. Furthermore, conditions such as retroversion of the uterus, often the result of failure of the womb to return to its normal position after childbirth, could have been detected by routine post-natal examination.<sup>47</sup>

The cost of the doctors' fees deterred many women from seeking help, particularly so soon after paying the costs incurred through the confinement. One mother described the torture she suffered from a 'falling womb' after the birth of her first child. It was ten months before she sought advice and the doctor then informed her that she should have reported it earlier and he could have soon put it right.<sup>48</sup> As Davies noted, many of the mothers were resigned to the notion that pain and motherhood were invariably connected.<sup>49</sup> This may explain the chronic nature of their complaints. At the Sheffield Hospital for Women one patient had suffered for some years from a vaginal fistula that constantly leaked urine, caused by an earlier difficult protracted labour. Another mother had suffered a ruptured perineum with the birth of her first child and the injury obviously got worse with subsequent pregnancies.<sup>50</sup> Similar cases presented in Birmingham and, as the medical staff noted, many women had suffered long and severely and yet, for a variety of reasons, neglected the aid of general hospitals.<sup>51</sup>

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<sup>47</sup> Retroversion – A backward displacement of the uterus from its normal anteverted position. Congenital retroversion seldom requires treatment. An acquired retroversion causes a number of painful and potentially serious complications that may require surgery.

<sup>48</sup> Davies, *Maternity*, p.38.

<sup>49</sup> *Ibid.*, pp.3-4.

<sup>50</sup> Mathers and McIntosh, *Born in Sheffield*, pp.34-35.

<sup>51</sup> BCA, BMHW, HC/WH 1/5/1, Medical Board, March 1872, HC/WH 3/1/1, In-patient Register, 1872-1892.

A further reason why women were reluctant to seek help was modesty; gynaecological examinations were a source of embarrassment for both patient and doctor in the nineteenth century. Tait had little patience with doctors who failed to ask the necessary questions or perform adequate examination to reach a diagnosis. Nevertheless, he understood women were unwilling to seek advice, particularly if it required discussing symptoms in a crowded out-patient department of a general hospital. Thus, great care was taken to avoid causing distress at the Women's Hospital. All patients were seen 'one by one' and chaperoned by a nurse, to ensure that 'every precaution (was) taken to avoid injury to the most delicate feeling'.<sup>52</sup> Medical students were allowed to attend the clinics for teaching purposes, provided they had completed their third winter session, had passed their first professional exam and had previous experience as a clinical clerk or surgical dresser. To avoid causing the patient further embarrassment, not more than two students were permitted at the same time and they were not permitted to visit the wards, unless accompanied by a medical officer. Qualified practitioners were also allowed to visit and observe the practice of the hospital, but similarly had to be accompanied by a medical officer. However, it was:

to be held as a general rule that the crowding of a large number of medical gentlemen either at operation or otherwise, is objectionable and contrary to the spirit of the regulations and to the design of the Charity: and in addition to and notwithstanding the above regulations, the

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<sup>52</sup> Ibid. HC/WH 1/5/1, Medical Board, March 1872.

objections of any patient to the presence of spectators is in all cases to be respected (emphasis in the original).<sup>53</sup>

As noted in the previous chapter, the rapid increase in the number of women attending the out-patient clinics soon put the department under pressure. Nevertheless, the lady Governors were determined that this should not affect patient care. Members of the Ladies Visiting Committee (discussed further below) were instructed to visit the out-patient clinics to see that order was preserved and 'ascertain from the patients themselves that they are being properly attended to'.<sup>54</sup> The ladies were asked to report any complaint to the House Committee and it is clear that they acted upon these instructions. The minutes of the Board of Governors reveal that Lawson Tait was written to in December 1883, following complaints from patients that he did not attend his clinic and that women went away without treatment. On checking the attendance book, it was found that there was no record of his work on other days. The Management Committee suggested that Tait obtain a substitute if he was unable to attend, or at least telephone to inform his patients of his delay. A similar letter was sent to Dr Hickenbotham, who had also failed to keep an accurate record of his work.<sup>55</sup>

Notwithstanding his occasional lapses, it would appear that Tait was popular with the patients. As noted in Chapter Two, Blanche Thompson recalled his out-patient days as the busiest in the week, perhaps because he showed much understanding of women's problems. As we have seen in the previous chapter, Tait spoke freely on subjects, such as masturbation, that were taboo to many Victorians. In *Diseases of Women*, he pleaded for sex

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<sup>53</sup> Ibid.

education and argued that it was 'the duty of every parent to give to every child, instructions in the nature and purport of sexual functions'. If this were to be done, he argued 'we should not only diminish sexual diseases, but we should greatly diminish sexual immoralities'.<sup>56</sup> Although by the 1880s some moral reformers were advocating sex education for children, there was little literature available, or consensus as to how this should be done.<sup>57</sup> The medical profession was divided on this issue. The *British Medical Journal* favoured teaching children the requisite basic anatomy and physiology but were uncertain how to inculcate respect for conventional Christian morality.<sup>58</sup> The *Lancet* argued 'that these were "essentially moral and religious questions" and should be dealt with on that basis'.<sup>59</sup> However, many believed that sexual ignorance was tantamount to respectability, especially for girls. Thus, the great majority of young women entered marriage 'almost as ignorant about sex and sexuality as when they left school'.<sup>60</sup> With hindsight, the authors of the letters contained in *Maternity* attribute much of their earlier suffering to ignorance. One wrote that, although she was twenty-eight when she married, she was in utter ignorance of the things that 'most vitally affect a wife and mother'.<sup>61</sup> It would appear that this woman's experience was common; in her interviews with working-class women, Roberts found that matters such as menstruation, sex and childbirth were seldom discussed in

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<sup>54</sup> Ibid., HC/WH 1/3/1, House Committee Minutes, 20 February 1877.

<sup>55</sup> Ibid., HC/WH 1/1/1, Board of Governors, 4 December 1883.

<sup>56</sup> Tait, *Diseases of Women*, p.91.

<sup>57</sup> See L.A. Hall, *Sex, Gender and Social Change in Britain Since 1880* (London, 2000), Chapter 2 for a discussion around the social purity movement which advocated such reform.

<sup>58</sup> *British Medical Journal*, 2 (1885), pp. 303-4. Cited *ibid.*, p.42.

<sup>59</sup> *Lancet*, 22 August, 1885, pp.350-51.

<sup>60</sup> Roberts, *A Woman's Place*, p.80.

<sup>61</sup> Davies, *Maternity*, p.187.



'respectable' families. As one Barrow girl put it, 'We were as innocent as the grave.'<sup>62</sup>

Conversely, there was a fall in the birth rate in the later decades of the nineteenth century. The average annual crude birth-rate per thousand of the population, which had been rising in the first half of the nineteenth century, reached its maximum in the decade 1861-70 and declined steadily thereafter.<sup>63</sup> A number of different theories for this phenomenon have been posited; however, the thesis put forward by Joseph Banks, in *Prosperity and Parenthood*, that economic imperatives were the key factor in the declining birth rate is widely accepted.<sup>64</sup> Whilst agreeing with the key points in this theory, Patricia Branca alerts us to the important role that women took in the decision to limit family size. Space does not allow a full discussion of the cogent argument, that birth control was a personal triumph for middle-class women and 'the most important ingredient to liberation', that Branca sets out in her book, *Silent Sisterhood*. Her point that 'birth control was the most practical way of coping with the unresolved problem of maternal mortality' is particularly well made.<sup>65</sup> From the mid-1870s, a growing number of occupations in the 'professional' or 'quasi-professional' categories joined the 'pioneers' of family limitation, that is, gentlemen of private means and those in the Registrar-General's Class 1 occupations.<sup>66</sup> By the 1890s, the birth rate had declined across all social classes, although the number of births by marriage remained significantly higher in manual occupations than in high

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<sup>62</sup> Roberts, *A Woman's Place*, p.80.

<sup>63</sup> J.A. Banks, *Victorian Values. Secularism and the Size of Families* (London, 1981), p.97.

<sup>64</sup> J.A. Banks, *Prosperity and Parenthood* (London, 1954).

<sup>65</sup> P. Branca, *Silent Sisterhood, Middle-Class Women in the Victorian Home* (London, 1975), p.114.

<sup>66</sup> Banks, *Victorian Values*, p.100, table 8.3.

status occupations. For example, the mean number of children born to barristers in marriages contracted 1881-91 was 2.50; for general labourers the number of births by marriage in this period was 5.67.<sup>67</sup>

Banks' thesis is supported by the more recent research of other historians. Ellen Ross, for example has shown that between 1880 and 1901, the fertility rate in middle-class suburban Hampstead fell nearly 30 per cent, whilst in working-class boroughs, like Poplar, it only fell by 6 per cent.<sup>68</sup> Certainly, mention of birth control in the *Maternity* letters is relatively infrequent. Thus, repeated pregnancies were common; one mother, who had her fifth child when her first born was six years old, describes how for those six years she never knew what it was to have a proper night's sleep, for if she was not breast feeding she was pregnant.<sup>69</sup> Similar stories of exhaustion and drudgery occur repeatedly and yet, as Davies acknowledged, the Co-operative Movement was largely composed of the better-paid manual workers. This would suggest that the domestic conditions of these women were above average for the working classes.

As noted in Chapter One, many of the working classes in Birmingham were tradesmen or semi-skilled workers, for example, carpenters, shoe makers, brass founders, button makers etc, or worked in the newer light industries that were becoming established in the town. Thus, like the Guild members, these families were above the class of 'labouring poor' and it is probable that their social circumstances were similar to those of the patients at the Women's Hospital. Certainly, it can be expected that Sparkhill was one of the branches that responded to the appeal. The members clearly had a

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<sup>67</sup> Ibid., p.100, table 8.3, p.106, table 8.5.

great deal of respect and affection for Llewelyn Davies. When her retirement was announced, they wrote, 'the fact is, we all love you, and don't want to lose you'.<sup>70</sup> The constituency of women in the *Maternity* survey is broadly similar to that of the patients, that is, married and in their childbearing years. The in-patient registers reveal that the majority of women, around 70 per cent, were in this category.<sup>71</sup> There are also a number of similarities in the occupations recorded for their husbands. Of particular interest are those in the survey employed in trades associated with Birmingham; among those listed we note a diamond worker, silversmith, jewel-case maker, brass finisher, screw-maker and electro-plate worker.<sup>72</sup> As may be expected, these trades are frequently recorded as the husband's occupation in the hospital records. The occupation of the women is often simply recorded as 'housewife'; among those married women who state an occupation, we find a merchant, whose husband's occupation is recorded as 'assay', a seamstress married to a tailor and a husband and wife whose occupations are recorded as tailors.<sup>73</sup> These are perhaps examples of the family run small-scale workshops discussed in Chapter One. There were 19 single women among the first 100 patients admitted; five described as 'at home' and seven were 'in service', including a housekeeper and a governess. Others were employed in occupations, such as 'jewellery' and button-making that were characteristic of the small trades that existed in Birmingham.

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<sup>68</sup> Ross, *Love and Toil*, p.94.

<sup>69</sup> *Ibid.*, p.50.

<sup>70</sup> Davies, *Maternity*, p.6.

<sup>71</sup> BCA, BMHW, HC/WH 3/1/1, In-patient Register, 1872-1892.

<sup>72</sup> Davies, *Maternity*, pp. 192-93.

<sup>73</sup> BCA, BMHW, HC 3/1/1, In-patient Register, 1872-1892.

As was made clear at the first public meeting, it was always the intention of the founders to accept patients able to make a small contribution to their maintenance whilst in hospital.<sup>74</sup> Accordingly, four of the eight beds were initially set aside for paying patients, although in practice, the arrangement never worked as intended, the priority being to admit to their full capacity. Private patients in the first 12 months included the wife of a Town Councillor and a vet's wife but working men, such as bricklayers, carpenters and a bedstead maker, were also willing to pay for their wives' medical care.<sup>75</sup> It is possible that the employers paid for the governess in the sample. As Moscucci has pointed out, pay beds resolved the difficulties faced by middle-class families if the governess became ill. Socially neither the equal of the family, but above the rank of servant, the governess occupied 'an indeterminate place within the middle-class home'.<sup>76</sup> Care at home incurred the cost of doctor's fees, also a governess would have lacked the necessary personal attention, as servants usually refused to wait on fellow members of the household.<sup>77</sup> Admission to hospital as a charity patient would have seemed unfeeling, but pay-beds avoided 'all indelicacy in mentioning the matter'.<sup>78</sup> Whosoever paid for their care, servants were often admitted as paying patients in Birmingham. The in-patient register shows that, in addition to the governess, three other servants were admitted as paying patients in the first year. A number of women were prepared to pay for their maintenance, including a 28-year-old 'home worker', suffering from metritis and a 46-year-old widow, with a fibroid of the uterus. Similarly, a young widow of 33 years,

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<sup>74</sup> Ibid., HC/WH 1/1/1 Board of Governors, 28 May 1871.

<sup>75</sup> Ibid., HC/WH 3/1/1, In-patient Register, 1871-1892.

<sup>76</sup> Moscucci, *The Science of Women*, p.96.

<sup>77</sup> Ibid.



suffering with a vesico-vaginal fistula was willing to make a contribution towards her care; following surgery, she was pronounced cured and was allowed home after 35 days. Particularly poignant was a 49-year-old woman whose occupation was described as brass worker. This unfortunate woman had a uterine tumour and was discharged after 17 days, 'unrelieved'.<sup>79</sup>

The majority of patients, however, were charity cases, typically middle-aged women of limited means and the wives of working-class men. Specifically excluded were 'those who could afford to pay and those who should go to the Parish Dispensary'.<sup>80</sup> Out-patients were admitted 'without note of recommendation' but, to prevent misuse, it was agreed that some enquires could be made into the patient's position in life. If subsequent enquiries at the patient's home revealed that she was in a position to pay for such attendance as her case required her name was '*to be at once removed from the list of free patients*'.<sup>81</sup> (emphasis in the original) The decision to exclude the 'labouring poor' may seem harsh but in truth these rules, which appear in the 'Laws' of the Institution, do not seem to have been rigidly applied. Nonetheless, the Governors acknowledged that they had to reconcile 'the rights of the medical profession, the claims of the public (and) the duties of the Charity'.<sup>82</sup> The ladies charged with drawing up guidelines acknowledged the difficulties with this. They argued that 'a patient's earnings had to be considered in relation to her general circumstances, the length of time she had been ill, the acuteness or reverse of her disorder, the number of

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<sup>78</sup> 'The Hospital for Ladies', *The Times*, 22 May 1865, p.9. Cited *ibid*.

<sup>79</sup> BCA, BMHW, HC/WH 3/1/1, In-Patient Register, 1871-1892.

<sup>80</sup> *Ibid.*, HC/WH, 1/1/1, Board of Governors, 3 October 1871.

<sup>81</sup> *Ibid.*, 23 May 1871.

<sup>82</sup> *Ibid.*, 3 October 1871.

children etc'.<sup>83</sup> Thus, it was impossible to lay down hard and fast rules, even for the labouring poor.

Table 3  
Statistical Tables of the Women's Hospital - 1882

Out-patients

	No of cases suitable	No of cases rejected	Total no of attendances
January	231	9	1218
February	208	18	1226
March	246	19	1374
April	178	10	1100
May	221	23	1375
June	223	19	1423
July	232	12	1362
August	229	11	1279
September	206	14	1223
October	208	10	1202
November	170	17	1086
December	66	6	609
Total	2,418	168	14,447

In-patients

	Free	Paying	Total	Average stay in hospital in days
January	21	-	21	22.4
February	23	-	23	23.2
March	23	-	23	19.8
April	23	-	23	18.6
May	20	-	20	20.2
June	24	-	24	15.5
July	19	1	20	25.9
August	20	1	21	15.0
September	23	-	23	23.8
October	20	-	20	22.0
November	24	-	24	23.8
December	19	-	19	20.2
Total	259	2	261	20.8

There was a feeling amongst contemporaries that it was the middle stratum of society that was most in need. A particular concern was the fate of the large numbers of single middle-class women unable to fulfil their

<sup>83</sup> Ibid., HC/WH 1/10/1, Annual Report, 1872.

expectation of marriage, due to the increasing numerical imbalance between women and men in the nineteenth century.<sup>84</sup> As the Ladies Committee of the Hospital for the Diseases of Women, Soho Square, pointed out, those 'unable to incur the expense of protracted medical treatment at home, yet shrink from the want of privacy and repose common in the wards of the general hospital (were), debarred from the advantages which the rich and destitute poor alike enjoy'.<sup>85</sup> Certainly, every effort was made at the Women's Hospital to create an environment in which the 'impoverished gentlewoman' would feel at home. Those who visited the wards noted that 'Such was their comfort that they scarcely conveyed the idea of a hospital. The walls were decorated with pictures, there were white dainty curtains for the beds, and sofas for the convalescents ... everything reminded one rather of the comforts of home.'<sup>86</sup> However, the patients did not remain long in hospital; the maximum stay permitted was one month, in practice it was often far less. In 1872 the average length of stay was 24 days, this decreased to 13 days in 1873.<sup>87</sup> This was far below the average in-patient stay at similar institutions. Ornella Moscucci has estimated that in the late 1860s it stood at around 92 days at the Hospital for the Diseases of Women, Soho Square.<sup>88</sup> Similarly, at Sophie Jex-Blake's Edinburgh Hospital for Women and Children many patients stayed for up to six weeks or two months.<sup>89</sup>

In part, this was due to the types of cases admitted. Around one third of patients admitted to the Edinburgh Hospital had organic disorders, for

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<sup>84</sup> Moscucci, *Science of Women*, p.95.

<sup>85</sup> Ibid., p.93.

<sup>86</sup> BCA, BMHW, HC/WH 1/10/1, Annual Report, March 1872.

<sup>87</sup> Ibid, HC/WH 1/5/1, Medical Board, March 1873.

<sup>88</sup> Moscucci, *The Science of Women*, p.89.

<sup>89</sup> Thomson, 'Women in Medicine', p.104 ff

example, 'eczema, rheumatism, varicose veins, bronchitis and tuberculosis'.<sup>90</sup> Gynaecological cases accounted for a further 25.6 per cent; however, the majority of women, over 82 per cent, had a range of inter-related functional complaints, either as a discreet illness or in association with some other ailment.<sup>91</sup> These included conditions such as weakness and debility, dyspepsia, acute constipation, with associated lassitude and abdominal pain, loss of appetite, anaemia, nervousness, insomnia and hysteria. In gynaecological patients the incidence of these conditions was even higher, with over 90 per cent of those who presented with gynaecological disorders being diagnosed as suffering from one or more these ailments.<sup>92</sup> Elaine Thomson has noted that the evidence from patients' records suggests that the treatment of many specific gynaecological and organic conditions was based on a holistic, functional understanding of illness.<sup>93</sup> Thus, douches and a carbolic washout 'were used in cases of miscarriage, 'flooding', leucorrhoea, menorrhagia and dysmenorrhoea, often in conjunction with a 'glycerine plug'.<sup>94</sup> Associated functional ailments, such as anaemia, weakness and debility, were treated with a regime of rest, strict attention to diet and often a tonic, to help to build up the body's strength.<sup>95</sup>

One such patient, 'Mrs 146', was admitted with leucorrhoea and a number of minor functional disorders, including back ache and bad appetite. After minor surgery, she was given a carbolic washout and subject to the usual therapeutic regime. Thomson does not record how long the patient stayed in

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<sup>90</sup> Ibid., p.143.

<sup>91</sup> Ibid., pp.143-44.

<sup>92</sup> Ibid.

<sup>93</sup> Ibid., p.145.

<sup>94</sup> Ibid., p.144.

<sup>95</sup> Ibid., pp.136, 144.



hospital, although as she was not discharged until her bowels and menstrual cycle had become regular, we can assume it was some weeks.<sup>96</sup> A comparative case at the Women's Hospital would have stayed in hospital between one and six days. As we have seen in Chapter One, the Charity was confined to the 'diseases peculiar to women' and, with few exceptions, this policy was adhered to. The primary purpose of the in-patient department was the surgical treatment of gynaecological conditions. Thus, it was the intention of the medical officers to utilize the beds in such a way that would result in 'the greatest benefit, to the largest number of patients, in the shortest possible time'.<sup>97</sup> To reinforce this, it was agreed that 'no bed was to be occupied an unreasonable length of time by one patient (and), before the patient had been in the hospital one month a consultation should be held on the case'.<sup>98</sup>

The case described above, which Thomson suggests was typical of many cases admitted with menstrual problems, illustrates the tension between women in medicine and male physicians, discussed in Chapter Two. As was shown, some women 'sought to temper male values by asserting their uniquely feminine characteristics', whilst others sought to emulate the scientific 'professionalism of men'.<sup>99</sup> For Jex-Blake, the former was the natural course. She wrote:

If any question arose respecting the relative fitness of men and women for attendance on the sick, the experience of daily life would go far to

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<sup>96</sup> Ibid., pp. 150-51.

<sup>97</sup> BCA, BMHW, HC/WH 1/10/1, Annual Report, March 1872.

<sup>98</sup> Ibid.

<sup>99</sup> R.M. Morantz-Sanchez, *Sympathy and Science. Women Physicians in American Medicine* (Oxford and New York, 1985) (2nd.1987), pp.200-01.

prove that, of the two, women have more love of medical work, and are naturally more inclined, and more fitted, for than most men.<sup>100</sup>

Thomson has argued that Jex-Blake and others were 'compelled to shape their practice to fit the arguments they had used to gain entry to the medical profession'.<sup>101</sup> Thereby, they emphasized the caring, nurturing qualities of their nature that reflected the Victorian concept of womanhood.

Moscucci has shown that the spiritual as well as physical needs of the patients were catered for at the Hospital for the Diseases of Women. She suggests that women were subjected to 'a disciplinary regime that bore a striking resemblance to the training of repenting prostitutes in Magdalen Institutions'.<sup>102</sup> Moscucci ascribes this to the strong spirit of Evangelicalism that motivated many of the subscribers; noting that lady visitors undertook to impart religious instruction and to read passages of the Bible to the patients.<sup>103</sup> Despite the deeply held religious beliefs of the Governors and subscribers, there is no evidence that there was any desire to combine physical healing with moral guidance in Birmingham. At the Women's Hospital, the Governors played a far more practical role. The House Committee dealt with the day-to-day management of the Institution, including the payment of invoices, ordering equipment and the recruitment and management of staff. In 1875, a decision was made to dispense with the services of the housekeeper, Miss Wood, the cook having agreed to take on

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<sup>100</sup> S. Jex-Blake, 'The Medical Education of Women' (1873), in D. Spender (ed.), *The Education Papers: Women's Quest for Equality in Britain, 1850-1912* (New York and London, 1987), pp.268-69.

<sup>101</sup> Thomson, 'Women in Medicine', p.141.

<sup>102</sup> Moscucci, *The Science of Women*, p.88.

<sup>103</sup> *Ibid.*, pp.87-88.

Miss Wood's duties, at a salary of £18 pa.<sup>104</sup> Perhaps by way of supervising the cook's housekeeping, Mrs Richard Chamberlain proposed that a Ladies Visiting Committee be established to visit the hospital at least twice each week. They were instructed 'to go into every ward and closet, the kitchen and dispensary and see the resident lady doctor'. Of paramount importance was the welfare of the patients and the ladies were told to 'take a convenient time of conversation with or reading to the patients and learning whether they had any complaint'.<sup>105</sup> This required a considerable commitment; they were expected to visit in rotation, once a fortnight, and get a substitute if they were unable to attend. It was agreed that a committee of thirteen be appointed, for a period of six months. Amongst these, were three Mrs Chamberlains, the wives of Richard, Arthur and Joseph, and Mrs Gladstone; others were of a similar social standing. Therefore, it may be expected that any complaint or adverse comment by the ladies received the full attention of the Management Committee. Perhaps of particular concern was the letter received from one of the lady visitors, Mrs Lakin Smith. The writer suggested that 'careful inquiry should be made into the character of nurses temporarily employed'.<sup>106</sup>

Initially, the Birmingham and Midland Counties Training Institute for Nurses supplied the hospital with nursing staff and probationers, as they did at the General Hospital, the Queen's Hospital and the Children's Hospital.<sup>107</sup> The Institute recruited the working-class girls that Florence Nightingale thought were ideal for the practical nature of nursing.<sup>108</sup> Aged between 25 and 35

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<sup>104</sup> BCA, BMHW, HC/WH 1/3/1, House Committee, 1874-1879, 21 September, 1876.

<sup>105</sup> Ibid., 20 February, 1877.

<sup>106</sup> Ibid., HC/WH 1/1/1, Board of Governors, 2 June 1879.

<sup>107</sup> S. Wildman, 'The Development of Nurse Training in the Birmingham Teaching Hospitals, 1869-1957', *International History of Nursing Journal*, 7:3 (2003), p.56.

<sup>108</sup> B.Abel-Smith, *A History of the Nursing Profession* (London, 1960), p.62.



years, the young women were expected to be able to 'read and write well (and) provide testimonials to their good character'.<sup>109</sup> Responsibility for the nursing services lay with the Medical Board, but the day-to-day management was delegated to the Honorary Lady Superintendent of that Institution, Mrs Tindall. It is unlikely that Mrs Tindall was a trained nurse; such 'honorary' positions were often filled by those who had 'lived in a respectable rank in life' but were now in 'reduced circumstances'.<sup>110</sup> The Superintendent was also responsible for their educational input, largely pamphlets of study material and lectures by medical staff, and undertook the examination of probationers for their certification. Following certification, probationers were expected to work for the Institute for a further two years, which allowed for a period of practice under supervision.<sup>111</sup> Historians have argued that nurse probationers were considered a 'cheap form of labour'.<sup>112</sup> It is apparent that probationers undertook some domestic work at the Women's Hospital, as a note was made when a young woman applied for voluntary training that 'no household duties were to be expected of her'.<sup>113</sup> It is unlikely they 'cleaned and scoured the wards' as previously, however, as servants were employed for general cleaning and heavy labour.<sup>114</sup>

During the middle decades of the nineteenth century, nursing became less menial in nature. Wider medical knowledge and the changing nature of medical treatment required a skilled assistant who could record observations and monitor the progress of patients, tasks formerly undertaken by doctors.

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<sup>109</sup> Wildman, 'The Development of Nurse Training', p.57.

<sup>110</sup> Abel-Smith, *A History of the Nursing Profession*, pp.7-8.

<sup>111</sup> Wildman, 'The Development of Nurse Training', p.57.

<sup>112</sup> See R. Dingwall, A.M. Rafferty and C. Webster (eds), *An Introduction to the Social History of Nursing* (London, 1988), pp.56-58, for an overview of nursing reforms.

<sup>113</sup> BCA, BMHW, 1/3/1, House Committee, 3 April 1877.



Thereby, the training of nurse probationers was directed towards meeting these expectations. Great emphasis was placed on strict compliance with the doctor's orders and observation of the patient, a practice greatly favoured by Lawson Tait. Writing on the post-operative care of a patient following ovariectomy, he wrote 'an intelligent woman for nurse, who will do as she is told, *and nothing more*, is absolutely essential'.<sup>115</sup> He added, 'If two such can be got to act as relays for the first eighty hours after the operation, it will be found a great advantage'.<sup>116</sup>

In the later decades of the nineteenth century, the influence of Florence Nightingale's teaching was paramount. To Nightingale, the underlying principles of nursing were clear: 'the effective, efficient and morally exemplary service of care to the patient'.<sup>117</sup> The object of nurse training was to fit them for this purpose. To succeed in this a nurse needed certain attributes, which are enshrined in the term a 'good and intelligent woman'. As Ann Bradshaw has noted, such qualities were fundamental to her training, which was a 'scientific practical preparation', and 'a moral, educative process'. Nightingale recognized the progressive nature of nursing and the importance of intellectual knowledge. She wrote, each year 'nurses have to learn new and improved methods, (and) year by year nurses are called upon to do more and better than they have done'.<sup>118</sup> Increase in knowledge was therefore important but of even greater benefit was wisdom, the practical application of

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<sup>114</sup> Dingwall et al., *Social History of Nursing*, p.23.

<sup>115</sup> Tait, *Diseases of Women*, p.167.

<sup>116</sup> Ibid.

<sup>117</sup> A. Bradshaw, *The Nurse Apprentice, 1860-1977* (Aldershot, 2001), p.3.

<sup>118</sup> F. Nightingale, 'Nursing the Sick', in M. Murray (ed.), *Quain's Dictionary of Medicine*, 3rd. ed., pp.1101-02. Cited *ibid.*, p.4.

knowledge. It was vital that nurses should use their minds: 'For the obedience of intelligence, not the obedience of slavery is what we want.'<sup>119</sup>

Understanding of Nightingale's philosophy is central to our perception of nursing in the late nineteenth and early twentieth centuries. Certainly, the influence of her teaching underpinned the practice of nursing at the Women's Hospital. The system of training was essentially an apprenticeship, linked to the needs of the hospital. The probationers were an important part of the nursing establishment, although voluntary probationers evidently had supernumerary status. A note was made that these 'ladies', often training with a view to joining the missionary hospitals in India, were not to replace those from the Nursing Institute. By 1878, the hospital thought that the Institution had reached the stage where it should be responsible for its own probationers.<sup>120</sup> To supervise these, two trained nurses from the Institute were employed by the hospital. In addition, extra staff were employed for 'special cases'.<sup>121</sup> The greatest difficulty lay in finding a suitable Head Nurse. Clearly, the hospital was seen as a useful stepping stone in their professional career. A number of senior nurses had been appointed and subsequently left the hospital since Mrs Tindell had retired.

The appointment of Miss Wilson (thereafter known as Sister Emily), in November 1879, provided a period of stability; she remained until she left the hospital to get married in July 1882.<sup>122</sup> Her successor, Margaret Lowndes, trained at St Bartholomew's Hospital, London, and was evidently a capable nurse. The medical staff regularly paid tribute to the 'satisfactory manner' in

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<sup>119</sup> F. Nightingale, *Florence Nightingale to her Nurses*, in R. Nash (ed.) (London, 1914), p.11. Cited *ibid.*, p.5.

<sup>120</sup> BCA, BMHW, HC/WH 1/3/1, House Committee, 19 March 1878.

<sup>121</sup> *Ibid.*, HC/WH 1/1/1 Board of Governors, 2 November 1875.

which she managed the in-patient department at Sparkhill. Particular note was made of her efforts in 1887, when there was a considerable increase in the number of major operations performed. The medical staff acknowledged that this made the work of Sister Margaret more arduous than usual and they wished 'to testify to her constant care for the patients in her charge'.<sup>123</sup> It is somewhat surprising, therefore, that in February 1889 the Management Committee reported that Miss Emily Nownes had been appointed sister-in-charge at Sparkhill.<sup>124</sup> Notwithstanding the fact that the minutes of the Management Committee became much briefer after 1889, it is perhaps surprising that no reference is made to her departure in the records. It is unlikely that there was any disagreement between Sister Margaret and the Governors; as will be seen in the following chapters, a new ward for infectious diseases was dedicated to her memory.

Little is known of Sister Margaret's successor, Sister Emily, as unfortunately the minutes of the Management Committee between April 1892 and May 1897 have not survived. The first record of her work appears in June 1897, but it is evident that life at the hospital was not running as smoothly as usual. The colouring of the walls, which was usually done once a year to prevent infection, had been omitted, and the laundry and kitchen maid had given notice to leave. More worryingly, there had been one death after surgery in May and the three deaths after operation in April.<sup>125</sup> This clearly was a downward trend; in 1888, the last full year Sister Margaret was in post,

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<sup>122</sup> Ibid., 4 November 1879, 4 July, 1882.

<sup>123</sup> Ibid., HC/WH 1/10/3, Annual Report, March 1888.

<sup>124</sup> Ibid., HC/WH 1/1/1, Board of Governors, 4 February 1889.

<sup>125</sup> Ibid., HC/WH 1/2/1, General Committee, 1 June 1897.

the mortality rate has been only 2.7 per cent.<sup>126</sup> A letter of resignation was received from Sister Emily in July of that year and it would appear that this was not entirely of her choosing. In her letter Emily Nownes makes reference to the 'very adverse report made by the Medical Board on the state of the nursing staff at Sparkhill'.<sup>127</sup> The following month an advertisement appeared in the *Nursing Record*, *The Hospital*, the *Medical Record* and the *Lancet* for 'a thoroughly capable lady to superintend the nursing and housekeeping at the inpatient department, Sparkhill'.<sup>128</sup>

It is not until 1902 that there was public acknowledgement that there had been problems with the nursing staff. Speaking at the Annual Meeting, George Hookham drew attention to the statistics for the mortality rates in the years between 1897 and 1900. He pointed out that in 1897 the mortality rate was practically 11 per cent and recalled the anxiety those figures gave them. They could not point to anything wrong in the hospital nor could they find any remission on the part of the medical staff. Much against their will, 'because they had the greatest liking and appreciation for the then matron' but it was clear that the nursing staff 'had got out of hand'. Since the new matron had been appointed the results were 'most interesting'.<sup>129</sup> In 1897 the mortality rate was 10.9 per cent; in 1898, 3.8 per cent; in 1899 and 1900 it was 2.94 per cent and in 1901 it was 4.2 per cent, giving an average of 3.1 per cent over the four years as compared with an average of 6.4 per cent for the previous four years.<sup>130</sup> Hookham commented that he was sure that the medical staff would be the last to claim that this was due in any great measure

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<sup>126</sup> Ibid., HC/WH 1/10/3, Annual Report, March 1888.

<sup>127</sup> Ibid., HC/WH 1/2/1, General Committee, 27 July 1897.

<sup>128</sup> Ibid.

<sup>129</sup> Ibid.



to any changes in their work over the last of four years. The improvements could only be ascribed to the more efficient management at Sparkhill and for that the credit must go to the new matron, Miss Richmond.<sup>131</sup>

Appointed in September 1897, Miss Richmond (her Christian name is not recorded), clearly intended to make some changes. Her first request, for an additional staff nurse, was readily granted, as was her demand for secure storage for poisons and a cupboard for the bedpans. She then set about compiling a complete set of 'rules' and 'did lists' for the approval of the House Committee. Records were kept of the average number of patients admitted, discharged and remaining in overnight, as well as the number of major and minor operations performed. Alongside these, the average number of patients, nurses on duty and the number of servants were recorded.<sup>132</sup> This attention to detail underpinned the efficient management of the hospital and, as indicated above, resulted in a higher standard of patient care. As will be shown in the following chapters, Miss Richmond stayed at the hospital for a number of years and made an important contribution to the development of care for the terminally ill. The more immediate need in the 1880s, however, was for some form of convalescent care.

From its foundation, there had been a year on year increase in the number of patients. In 1877, there were 2,092 new cases in the out-patient department, and 74 cases admitted as in-patients; in 1882, the comparative figures were 2,418 out-patients and 261 in-patients.<sup>133</sup> As noted above, there was also a steady increase in major surgery in the early 1880s. For example,

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<sup>130</sup> Ibid., HC/WH 1/10/4, Annual Report, March 1902.

<sup>131</sup> Ibid.

<sup>132</sup> Ibid., HC/WH 1/2/1, 12 October and 2 November 1897.

<sup>133</sup> Ibid., HC/WH 1/10/1, Annual Report, 1877.

in 1882, abdominal sections accounted for 116 of the 196 operations; the length of stay increased to reflect the nature of the surgery performed and was just under 21 days in this year.<sup>134</sup> With a relatively short stay in hospital, the conditions women returned home to after discharge were important; such operations required, as indeed they do today, a period of recovery and rest from heavy labour. It is difficult to judge individual domestic circumstances, but the in-patient registers show that the social mix of patients was much the same as in the early years; a few professional families of limited means, the lower-middle class, artisans and the 'respectable poor'.<sup>135</sup> As suggested above, a meagre diet, particularly for women, and over-crowded, insanitary living conditions were common amongst the working classes in the nineteenth century. All these factors mitigated against further recovery after discharge from hospital.

This fact would not have escaped the attention of the Governors, who, as mentioned in Chapter One, worked with other charities in the town. Alice Beale, a Governor from the foundation of the Institution, was likely to be particularly well-informed. The Birmingham Settlement, which she helped to establish, was in one of the most deprived areas in the town.<sup>136</sup> The initial suggestion of continuing the treatment of patients after discharge came from a member of the Ladies Visiting Committee, Mrs Lakin Smith, in August 1882.<sup>137</sup> In the ensuing discussion at the Board of Governors, the Chairman was doubtful if it could be done, as the hospital did not have the funds, even

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<sup>134</sup> Ibid., HC/WH 1/5/1, Medical Report, March 1883.

<sup>135</sup> Ibid., HC/WH 3/1/1 In-Patient Register 1871-1892.

<sup>136</sup> M.D. Green, *Images of England. Birmingham Women* (Stroud, 2000), p.55.

<sup>137</sup> BCA, BMHW, HC/WH 1/1/1, Board of Governors, 1 August 1882.

for its 'proper work'.<sup>138</sup> This was evidently true; the previous year Lawson Tait and Thomas Savage had felt so strongly about the necessity of having three more cottage wards, they had offered to make a donation of £50 each, with a further £300 over the next three years, in total £700.<sup>139</sup> The Chairman had declined their offer, as the Committee could not undertake the increased expenditure running the wards would cost. He felt obliged to give a similar response to Mrs Lakin Smith, but the usefulness of the suggestion struck the Management Committee and he did offer her some hope. The Committee 'would be glad to co-operate if she could set such a movement afoot'.<sup>140</sup>

Accordingly, the Ladies Committee decided to raise the money independently. A Convalescent Fund was started and, aided by gifts of £500 each from Mrs James and Miss Chamberlain; within a year sufficient funds had been raised to put a variety of schemes in place.<sup>141</sup> Twenty-two patients went to a nursing home in Stratford-upon-Avon, for periods of a fortnight to a month, or longer according to their need. This home was felt to be ideal for those who needed rest, country air and good food. The Committee was of the view that patients did best in 'smaller homes than large ones, where they are expected to perform some amount of housework'.<sup>142</sup> Patients included 'a young orphan girl with no home' who, after a serious operation, was sent to Stratford to regain her strength and Mrs R., who was 'very poor and very weak' and could not get sufficient food at home. Not all patients were able to travel so far, however. Thus, accommodation was found in a 'cottage home' in near-by Selly Park, where those like Mrs G., 'a weakly delicate woman, not

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<sup>138</sup> Ibid.

<sup>139</sup> Ibid., 1 November 1881.

<sup>140</sup> Ibid., 1 August 1882.

<sup>141</sup> Ibid., 1 May 1883.

fit to go home to attend to her family' received 'careful attention and home comforts'.<sup>143</sup> For those who still required surgical dressings, but needed to return home to their families, the services of Birmingham District Nurse Society were called upon.<sup>144</sup>

In total, forty patients received convalescent or home care during 1886, by 1893, this number had increased to eighty-eight.<sup>145</sup> The patients were sent either to 'Mrs Hiley's Cottage Home' or to the Nursing Home in Stratford. Mrs Hiley's Home was particularly favoured. A retired nurse, she had been previously employed at the hospital and the Sister in charge was able to 'entrust patients to her care at a very early stage of their convalescence'.<sup>146</sup> The Home was only a few minutes walk from the hospital and the Lady Visitors were able to ascertain for themselves, and by talking to the patients, 'that their food is good and plentiful, and that they are cared for in every way'.<sup>147</sup> The proximity of the Home was particularly convenient when beds at the hospital were urgently needed for admissions, but it is clear that the medical staff abused Mrs Hiley's willingness to oblige. The records suggest that there was some dispute between lay Governors and the medical staff regarding the appropriate length of stay of post-operative patients. Lengthy correspondence between the Honorary Secretary, then Mr Nettlefold, and Dr Jordan, reveals the seriousness of this disagreement. The complaint centred on two patients, Mrs B. had been discharged home on her twelfth post-operative day and had evidently not progressed as expected. Mrs R., who

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<sup>142</sup> Ibid., HC/WH 1/10/2, Report of the Convalescent Fund, Annual Report, March 1884.

<sup>143</sup> Ibid.

<sup>144</sup> Ibid.

<sup>145</sup> Ibid., HC/WH 1/10/4 Report of the Convalescent Fund, Annual Report, March 1893.

<sup>146</sup> Ibid.

<sup>147</sup> Ibid.



had not required surgery, was sent to the Convalescent Home 'before she was in a convalescent state'.<sup>148</sup> Mr Jordan replied, giving apparently plausible explanations for each case but, clearly briefed by one of the Lady Visitors, Nettlefold had his facts before him and remained unconvinced. He wrote:

The Convalescent Home was never intended for the reception of such patients ... the committee is also aware that there is great pressure on your beds and they cannot help connecting these two facts, but in their opinion there ought to be no such connection. They would be glad if you would give an explanation.<sup>149</sup>

The above correspondence is a rare example of the occasional disagreements between professional and lay staff. The impression gained from reading contemporary accounts suggests a cordial relationship existed between medical staff and Governors. Certainly, the Governors took a paternal interest in the welfare of the nursing and domestic staff. Learning that Mrs Newton, one of the oldest nurses at the out-patient department in Upper Priory was 'quite past her work', it was agreed that she should be 'relieved of her work and receive an allowance of 7/- per week for a period not exceeding one year, the matter then to receive further consideration'.<sup>150</sup> Staff were also beneficiaries of convalescent care. In 1892, two nurses were given their board and railway expenses for a fortnights holiday in Rhyl. The following year the gardener was sent to Wales for two weeks holiday, to recover from a severe attack of sciatica. In the same year a nurse, who

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<sup>148</sup> Ibid., HC/WH 1/2/1, Management Committee, 14 November 1899.

<sup>149</sup> Ibid.

<sup>150</sup> Ibid., 2 November 1897.

became ill shortly before she was due to leave to become married, was sent for eight weeks holiday, all expenses being paid.<sup>151</sup>

As the Committee of the Convalescent Home (established in 1899) noted, convalescent care for nursing staff put considerable pressure on the resources available, although Arthur Chamberlain believed that such a cost should never be grudged. He pointed out that 'Their work was most exhausting, and was very liable to destroy their health from time to time.'<sup>152</sup> The main purpose of the Convalescent Home, however, was 'to restore to their homes in complete health those who had been saved by the operative skill of the surgeon'.<sup>153</sup> Chamberlain paid tribute to the ladies who had undertaken that under their care, noting that 'those who had suffered from illness knew how bad was the period of convalescence... if that was the case with people in a comfortable position, they knew it must be much more so in the case of the poor people whose sufferings they set themselves to relieve'.<sup>154</sup> Chamberlain (then President of the hospital), regarded convalescent care as one of the most important aspects of their work and suggested that should be kept up, whatever the state of the funds. He urged those charged with the management of the hospital 'to make any contribution that was required in order to enable the work of the Convalescent Home to go on'.<sup>155</sup> Certainly, support was needed; 120 patients had been admitted the previous year, only fourteen of whom had been able to make any contribution to their maintenance. Nonetheless, presenting their Report in 1902, the Committee of the Convalescent Home were glad to be able to look back on a

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<sup>151</sup> Ibid., HC/WH 1/10/2, Report of Convalescent Fund, March 1884, March 1885.

<sup>152</sup> Ibid., HC/WH 1/10/4, Annual Report, March 1902.

<sup>153</sup> Ibid., Annual Report, March 1889.

<sup>154</sup> Ibid.

year's satisfactory work and noted that the Home afforded, 'especially for the most needy and friendless', the care essential to their recovery.<sup>156</sup>

The purpose of this chapter has been to build a picture of the women who attended the Women's Hospital in the late nineteenth and early twentieth century and to gain a clearer understanding of the circumstances of their lives. We have learnt from contemporary accounts of the poverty and toil which, combined with frequent pregnancies and sometimes indifferent obstetric care contributed to poor health. For many women, the hardship of their lives resulted in chronic ill-health, with diseases such as anaemia and varicose veins. Furthermore, a significant number of women were left with a range of physical conditions, such as prolapsed womb and chronic pelvic infection or fibroids, which required surgery and intensive post-operative care. 'Caring' is often portrayed as the essence of nursing but this obscures the practical nature of nursing; it also fails to acknowledge the importance of management skills.<sup>157</sup> As has been illustrated, failure to manage the hospital efficiently had serious implications for the patients and Governors alike. A further aim of this chapter was to consider how far the gender of the practitioner influenced the medical care and treatment of women. An important consideration is the difference in the type of patients admitted. We have seen that at Jex-Blake's Hospital in Edinburgh one third of the patients admitted had organic complaints such as eczema, rheumatism and varicose veins. Gynaecological patients accounted for only twenty-five per cent of

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<sup>155</sup> Ibid., Annual Report, March 1902.

<sup>156</sup> Ibid., HC/WH 1/10/4, Report of Convalescent Home, March 1901.

<sup>157</sup> Tom Olson has challenged the assumption that nursing equals caring. See, T. Olson, 'Ordered to Care?: Professionalization, Gender and the Language of Training, 1915-37', in A.M. Rafferty, J. Robinson and R. Elkan (eds), *Nursing History and the Politics of Welfare* (London and New York, 1997), pp.150-63.

women admitted and these were limited to minor conditions such as miscarriage.

Undoubtedly, the holistic approach adopted by Jex-Blake would have resulted in improved general health and sense of well-being for the woman concerned. However, it would have done little to address any underlying problem, such as a prolapsed womb or fibroids. By comparison, the Women's Hospital was confined to gynaecological disease and exceptions were only made in cases where the nature of the complaint, for example haemorrhoids, would have caused the woman embarrassment in a general out-patient clinic. The primary purpose of the hospital was the surgical treatment of gynaecological conditions. Nevertheless, the general health of the woman was also considered which led to the introduction of convalescent care. Thereby, women were more likely to gain long-term benefit from the treatment and care they had received. It would be misleading to suggest that the different approach to health care was linked to gender; we have seen in the previous chapter that Garrett Anderson and other female practitioners similarly adopted a surgical approach. It is more likely that medical practice was influenced by the preference of the individual; as with male practitioners, some women doctors clearly preferred the role of physician to surgeon. In conclusion, two themes emerged from this chapter; the necessity of education for birth attendants and the need for convalescent care. As will be shown in the following chapters, these issues were addressed in the early decades of the twentieth century.



## **Chapter 5**

### ***Challenges and Opportunities***

#### ***Gynaecology at the Women's Hospital c.1905 -1948.***

In the previous chapters we have examined the hospital's early years during which it established its position as an integral part of the voluntary hospital system in Birmingham. The purpose of this chapter is to explore the development of the gynaecological service at Sparkhill, from the opening of the new hospital in 1905 to the advent of the National Health Service in 1948. We will consider how the Governors conducted the policy and affairs of the Institution and how they responded to the challenges faced by the voluntary hospital system during the inter-war years. During this period the method of funding changed significantly; increasingly there was less reliance on private subscriptions and a greater dependence on contributions from the working classes through contributory schemes. As will be demonstrated, finance continued to be a perennial problem as the costs associated with running the hospital increased. These were largely due to the changes in medical practice in the early decades of the twentieth century. Developments in pathological anatomy and microscopy (discussed in Chapter Three), had led to greater understanding of the disease process. For example, the identification of the bacteria associated with surgical infections in the 1880s and the subsequent adoption of the aseptic technique had reduced the incidence of post-operative infection.<sup>1</sup> There were also new methods of treatment, such as radium treatment for carcinoma of the cervix and a greater

demand for laboratory aids to medicine, such as x-ray equipment and pathological analysis. Thus, the modern hospital in the 1930s was a much larger unit than the old-style voluntary hospitals and employed a number of professional and technical staff. These further added to the costs involved in running such institutions and it is doubtful if the hospital could have afforded the additional services needed without the support of local charities and the fundraising efforts of the Women's Hospital League. We begin, however, with what was regarded by those present, as a landmark in the hospital's history, the opening of the new hospital, in Showell Green Lane, in 1905.

Arthur Chamberlain (then President) used the occasion to review what the Institution had accomplished thus far. He attributed the international recognition which they had achieved in the field of gynaecological surgery to the 'genius of Lawson Tait'.<sup>2</sup> He was also proud of the fact that the hospital was one of the first in the country to publish their mortality statistics in detail. Their most important and fortunate decision, however, and one to which he attributed a great deal of their success, was the inclusion of women Governors in the management of the hospital. This gave them 'the advantage of having at first hand the benefit of a lady's opinion on a subject so closely connected with the interest of their sex'.<sup>3</sup> Chamberlain cited population growth as one reason to justify the new hospital and certainly this argument was valid. As noted in Chapter One, when the Institution was founded in 1871 the population of Birmingham was around 370,000; by 1903 this had risen to

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<sup>1</sup> S. Cherry, *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge, 1996), pp. 18-19.

<sup>2</sup> Birmingham City Archives (hereafter, BCA), Archives of The Birmingham and Midland Hospital for Women (hereafter, BMHW), HC/WH 1/10/5, Annual Report, 1903.

<sup>3</sup> *Ibid.*

530,300.<sup>4</sup> As may be expected, there was a corresponding rise in the number of women requiring medical care; in 1903, 444 patients had been admitted, the largest number that had passed through the hospital in any one year. Inevitably, this put pressure on the beds and, by the end of the year, women were waiting twelve to eighteen months for admission.<sup>5</sup> Furthermore, as shown in the previous chapter, the current accommodation in Stratford Road was not suitable for the requirements of a modern hospital. Plans for redevelopment in 1899 had to be abandoned due to a lack of capital, but by 1903 sufficient funds had been pledged to begin construction and a plot of land was acquired in Sparkhill, for £3,850. The site, which also accommodated the new convalescent home, was a 'wealth of light and air and sunshine, facing Showell Green Lane and backing on to Sparkhill Park'.<sup>6</sup>

After more than thirty years in 'make-shift' accommodation the Governors were determined that the new hospital would be 'as perfect as they thought it could be and should be'.<sup>7</sup> As Keir Waddington has noted, Governors who were actively involved in the administration of an institution had to visit the hospital on a regular basis; this could require weekly visits or more in the case of the Chairman or Treasurer.<sup>8</sup> It is likely that, during this major building programme, some members of the Management Committee had to attend almost on a daily basis. The design of the hospital allowed for 50 beds, including 8 beds for paying patients, accommodation for the nursing staff and an administrative block, which could be adapted to provide a further 20 beds if

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<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

<sup>7</sup> Ibid., Annual Report, 1905.

<sup>8</sup> K. Waddington, *Charity and the London Hospitals 1850-1898* (London, 2000), p.148.

necessary.<sup>9</sup> The management of this project demonstrates the value of the considerable business expertise of the Governors although this was not unusual; elsewhere most Governors of voluntary institutions had business interests or came from a professional background, such as law or finance.<sup>10</sup> Nonetheless, these were not the 'men of leisure' historians have described.<sup>11</sup> Throughout the years that Arthur Chamberlain was promoting the growth and development of the Women's Hospital he was at the height of his business career.

Most of Chamberlain's colleagues were similarly involved but, notwithstanding their business commitments, many of the lay Governors served 30 years or more, as did a number of the medical staff. This gave the Institution a sense of continuity, particularly as younger generations of the same families continued the tradition of service throughout this period; Mrs Neville Chamberlain, wife of the Prime Minister, was President of the hospital throughout the years of World War Two. This instilled a sense of responsibility which implied a duty to manage the affairs of the hospital with the same attention to detail as they would a family business concern. There was also a need to justify in the eyes of their subscribers all the expenditure which had been incurred. Thus the Chairman, Councillor Nettlefold, described in some detail the costs of the new hospital and convalescent home. The total cost of the Women's Hospital was £464 per bed and in the Convalescent Home, £206 per bed. Nettlefold pointed out that they were £5 per bed cheaper than two other new hospitals that had recently been built; moreover, they were better value for money as they had included many items

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<sup>9</sup> BCA, BMHW, HC/WH 1/6/1, Building Sub Committee, 1902-03.



that other hospitals had omitted. Nettlefold said this economic result had only been obtained by the most careful scrutiny by the architect, the Committee and everybody connected with the building. They had all wanted 'the best possible hospital for the work they had to do but they had set their face rigidly against any fads'.<sup>12</sup>

The new hospital was formally opened on 20 September 1905 by Chamberlain's daughter, Mrs John S. Nettlefold. Around 500 people attended, amongst whom were Mr Samuel Lloyd, one of the original trustees, the Rt Hon. William Kenrick and the Bishop of Birmingham, who had been invited to say prayers on the occasion. The Bishop rejoiced in the fact that the hospital had been successfully founded and had grown from small beginnings. He said 'they knew how grievous was the sickness among women (and) how much the evils of our civilisation tended to aggravate them'.<sup>13</sup> Professor Taylor said he was pleased with the new building as it would offer better facilities for their work and better accommodation for patients and nurses. He also observed that the new hospital would allow them to further develop their links with the Medical School. As noted in Chapter One, medical students had been attending the out-patient clinics since the 1870s but due to the cramped conditions on the wards the current arrangement was for medical students to get their clinical teaching at the Queen's Hospital. As Taylor pointed out, this arrangement was not satisfactory and as Professor of Gynaecology at the University he should supervise their teaching. He was hopeful that with the more spacious

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<sup>10</sup> Waddington, *Charity and the London Hospitals*, p.149.

<sup>11</sup> B. Harrison, 'Philanthropy and the Victorians', *Victorian Studies*, ix (1966), pp.353-74.

<sup>12</sup> BCA, BMHW, HC/WH 1/10/5, Annual Report, 1905.

<sup>13</sup> Ibid.

accommodation now available they would be able to undertake clinical teaching on the wards. Taylor also stressed the necessity for a pathology department to be provided to allow surgeons to take full advantage of the recent developments in laboratory medicine.<sup>14</sup>

Chamberlain acknowledged that there were still a few things to be done; it was, as usual, a question of money. As late as April 1904 it was reported that a further £8,000 was still needed if the hospital was to be opened free of debt. An urgent appeal for donations was made, with each subscriber being asked to recruit a friend. A further suggestion was to donate £1,000 to endow a bed, perhaps in memory of loved ones or friends. Chamberlain said he did not understand the small subscription list, women were no less deserving than others and their need was so great. He appealed especially to the men, saying 'women have so many claims on us all, as fathers, husbands and citizens'.<sup>15</sup> As Chamberlain noted, many industrialists in the town gave nothing at all to charity; however, substantial donations continued to be received annually from the leading families, notably the Chamberlain, Kendrick and Cadbury families. Whilst their ongoing support of this Institution cannot be explained by any single reason, the religious beliefs of these families remained a major influence in their lives. The Unitarian background of many of the Governors instilled in them a 'profound sense of duty (and) an understanding of the responsibilities that wealth and privilege incur'.<sup>16</sup> The Unitarian and Quaker industrial aristocracy of Birmingham were acutely aware, however, that private charity was not sufficient; thus, their efforts were

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<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> A.J. Crozier, 'Chamberlain (Arthur) Neville (1869-1940), *Prime Minister*', <http://www.oxforddnb.com/articles/32/32347>, accessed 01/07/2007.

directed towards improving the quality of life for the deprived classes. As we have seen in Chapter One, through their involvement with local government they sought to tackle such issues as slum clearance and the provision of schools and libraries. It would appear that their sense of social obligation was combined with an element of civic pride; although many of these families were only second or third generation migrants to the district there was a strong sense of loyalty to the city; as William Kenrick said, they were 'all Birmingham men'.<sup>17</sup>

The Women's Hospital also had the deep and active support of the local community. The most significant sums were subscribed by the Sparkbrook Friendly Societies, who raised the sum of £450 at their annual church parade and flower show in 1910 and a further £618 the following year.<sup>18</sup> As Chamberlain noted, that organization was entirely composed of the classes for whom the hospital catered and the success they had in raising these 'magnificent amounts' meant that almost half of their income came from patients and their families. This was most encouraging as it was felt to be 'the most practical proof possible that their work was well done'.<sup>19</sup> Notwithstanding this level of support, the Institution struggled in the early years to establish a sound financial basis and within three months of its opening the hospital had acquired a deficit of £1,500.<sup>20</sup> Clearly there was an urgent need to increase its income if the work of the hospital was to carry on. An ongoing problem was the number of women coming from the surrounding districts. The Charity had a long-standing rule that £4 per annum was required

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<sup>17</sup> A. Briggs, *History of Birmingham, Volume II, Borough and City 1865-1938* (Oxford, 1952), p.150.

<sup>18</sup> BCA, BMWH, HCWH 1/10/5, Annual Reports, 1910, 1911.

<sup>19</sup> *Ibid.*, Annual Report, 1910.

from subscribers within a 25-mile radius of Birmingham. This had been amended in 1900, when a 'topographical analysis' had shown that 105 patients had been admitted to the hospital from districts outside Birmingham, but within the 25-mile radius. The cost of treating these patients was £480 4s 6d; subscriptions received from these districts amounted to £161 4s 6d, resulting in a net loss of £319 3s 0d.<sup>21</sup> Clearly this was unsustainable and the £4 rule was reduced from 25 miles to 10 miles.<sup>22</sup> This was further amended in 1908, when the fee was increased to £6.<sup>23</sup> Minor initiatives such as this, however, were never going to solve the problem and in September 1907 a meeting was held at the new Central Hall with the immediate aim of encouraging more women to take an interest in the work of the hospital.

It is likely that attendance at this meeting was promising; women made a significant financial contribution to charity in Victorian England and whilst they showed an interest in a wide range of charities, women preferred to contribute to charities dealing with the problems of women and children. Not surprisingly they invested even more in charities where women were included in the management and the more power women held the more likely they were to contribute. For example, the Ladies Benevolent Society, the Friendly Female Society and the Women's Vegetarian Union all received 80 per cent of their subscriptions from women.<sup>24</sup> It was not just a question of their financial contribution, women had made philanthropy their 'own profession' since the early decades of the nineteenth century. This most often took the form of visiting the poor, either in their homes or in public institutions; sanitary reform

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<sup>20</sup> *Ibid.*, Annual Report, 1905.

<sup>21</sup> *Ibid.*, HC/WH 1/2/1, Management Committee, 12 June 1900.

<sup>22</sup> *Ibid.*, 11 September 1900.

<sup>23</sup> *Ibid.*, HC/WH 1/10/5, Annual Report, 1908.



and education were other areas to which women contributed. By the later decades of the century women were extending their activities into the field of public service, such as serving as Poor Law Guardians or on Local Government Boards. Others became paid officials of charitable societies; it was estimated that there were 20,000 women working as paid officials of charitable societies in 1893, whilst a further half a million women were voluntary workers.<sup>25</sup> The professionalization of philanthropy inspired greater organization of like-minded women, such as the Union of Women Workers which was established in several large cities, including Birmingham. The purpose of the Union was to bring women together to discuss aspects of their philanthropic work, with the object of influencing public opinion on issues such as the appointment of female Poor Law Guardians. Writing in 1893, Emily James claimed that through the Union, the public had 'learned a new respect for the capacity of women'.<sup>26</sup>

The outcome of the meeting at the Town Hall was the formation of the Women's Hospital League; its first task was to make up the annual deficit of around £1,000 per annum; then it was hoped that money could be raised for other hospitals in the city. The League had a lot of work to do to deal with the deficiency, particularly the cost of treating patients attending the hospital from outlying districts. As the Chairman pointed out, the hospital was supported almost entirely by residents in and around Birmingham and the Committee of Management considered it 'only fair that if patients from a distance were admitted, their costs should not be defrayed by the subscribers in

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<sup>24</sup> F.K. Prochaska, *Women and Philanthropy in 19<sup>th</sup> Century England* (Oxford, 1980), p.33.

<sup>25</sup> P. Hollis, *Women in English Local Government 1865-1914* (Oxford, 1987), pp. 223-24.

<sup>26</sup> *Ibid.*, p.257.

Birmingham'.<sup>27</sup> The League set about addressing this problem; meetings were arranged in Birmingham and the outlying districts at which Mrs Nettlefold spoke to local women about the work of the hospital. The *Evening Dispatch* greatly assisted their efforts by running a co-ordinated advertising campaign. It would appear these ladies had a flair for fundraising; in their first year the League raised £57 in new annual subscriptions and £478 in donations and entertainments.<sup>28</sup> At the Annual Meeting in 1909, it was reported that in the first three months of the year the League had already raised £167 in subscriptions. More importantly, several new Branches had been established, including those at King's Norton, Sutton, Handsworth, Northfield, Moseley, Perry Bar, Erdington and Solihull.<sup>29</sup> On hearing about their work, John Chamberlain (Honorary Treasurer) said that the accounts of the hospital did not paint such a black picture after all. The financial situation was also improving generally, with subscriptions, donations and the charity boxes all yielding extra income. The Management Committee were also encouraged by the fact that costs had been reduced in the new hospital; housekeeping was down £30 per annum, which they realised might not seem a very large sum, but they reminded their audience that the number of patients treated was identical. In 1907 the annual cost per patient was £107 0s 3d: in 1908 the comparative cost was £103 12s 6d. The Chairman suggested that 'the ladies present at least must have realised the care and attention that Miss Richmond had given to her budget to achieve that result'.<sup>30</sup>

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<sup>27</sup> BCA, BMHW, HC/WH 1/10/5, Annual Report, 1908.

<sup>28</sup> Ibid.

<sup>29</sup> Ibid.

<sup>30</sup> Ibid.

Richmond was perhaps following the example set by the Management Committee, who looked constantly for savings. For example, in June 1910 they contacted several coal merchants with a view to reducing the price; subsequently they managed to get a quote which represented 10/6 per cwt, or 1/- less than the previous year.<sup>31</sup> On the appointment of a new Honorary Treasurer, Herbert Martin, in 1911, they took the opportunity to review the administrative arrangements of the hospital. The Committee had previously employed a collector, Mr Jones, whose job it was to improve and increase the annual subscriptions. Jones received a percentage of the subscriptions he collected but it would appear that he could not be fully trusted. The Honorary Secretary reported that he had had several meetings with Jones and subsequently had given him formal notice. It was decided that in future the books of both the Maternity Hospital and the Women's Hospital were to be kept by a bookkeeper, who would be provided with an office and the equipment needed for the efficient management of the administrative records and accounts of the hospitals. The person appointed was to be given an office adjacent to that of the Honorary Secretary, so that it was under his personal supervision. It was anticipated that these arrangements would cost around £125 per annum but they would ensure that the work of the hospital was more efficiently done in the longer term; this would result in considerable savings.<sup>32</sup> At the Annual Meeting in 1913, Martin reported that he had adopted a system of accounting that had been recommended by the Central Hospital Board in London. He said there were considerable advantages in the new system in that they could compare their expenditure to that of similar

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<sup>31</sup> *Ibid.*, Annual Report, 1910.

hospitals. This had made it easy to identify a higher than average expenditure in any particular department and this had already proved very useful to them. In particular, one economy which he hoped to make was related to coal, water, gas, electric lighting, etc. which had cost them £1,120 the previous year. With this in view he had asked a firm of consulting engineers to consider the whole question of their expenditure on utilities and he hoped that he would be able to present a better picture at the end of the current year.<sup>33</sup>

The same frugal approach was not taken in matters relating to patient care. Wherever possible, no expense was spared if the treatment would be beneficial to the patient. For example, Annie Clark wrote to the Management Committee in 1910, to report that it had recently been found that if radium was applied on x-rays after surgery for the removal of malignant growths, it lessened the chance of a malignancy returning. Whilst this was usually done during or directly after the operation this was not essential, as the x-rays could be applied after the patient had been discharged. A local practitioner, Dr Hall Edwards was willing to do this at his rooms at 30/- per case for patients from the Women's Hospital. Private patients would be able to meet the expense themselves, but charity patients would be unable to pay and the Medical Board wished to know if, in these circumstances, the Management Committee would be willing to meet the cost. The Management Committee agreed that £20 per annum be allocated for this treatment and asked to be kept informed of the progress of these patients from time to time.<sup>34</sup> In those cases where the Management Committee were unable to fund requests for new equipment

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<sup>32</sup> Ibid., HC/WH 1/2/4, Management Committee, 10 October 1911.



an effort was made to find interim arrangements. As noted above, the Governors recognized the need for a pathology laboratory but as the hospital was still £1,000 in debt in 1907, they could not afford to build a laboratory at that time. After consultation with the Medical Board it was agreed that all pathology work would be done externally, at a cost of 60 guineas per annum.<sup>35</sup> Such arrangements were not unusual, particularly in regard to x-ray apparatus. The equipment was expensive to purchase and it rapidly depreciated in value. Many hospitals preferred to use the x-ray facilities at other hospitals or central institutions as an alternative. For example, the Cancer Hospital in Manchester had purchased x-ray equipment in 1901 but found that it was difficult to maintain and hardly worthwhile, for the amount of cases treated. They subsequently sent suitable patients either to the Infirmary or to the Skin Hospital (to whom they donated their equipment) for treatment.<sup>36</sup>

As has been shown in previous chapters, the Governors never limited their interest to financial matters and took a keen and active interest in the clinical work of the hospital. Costs were measured in terms of patients cured which is how they judged their success; hence their annual reporting of the mortality rate for the previous year. At the Annual Meeting in 1905, Chamberlain expressed satisfaction with the mortality rate, which had been 2 per cent for 1904, noting that this compared very favourably with the previous year when the mortality rate was 4 per cent.<sup>37</sup> In response, Professor Taylor said he

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<sup>33</sup> Ibid., HC/WH, 1/10/5, Annual Report, 1912.

<sup>34</sup> Ibid., HC/WH 1/2/5, Management Committee, 3 April 1910.

<sup>35</sup> Ibid., HC/WH 1/2/4, Management Committee, 19 December 1907.

<sup>36</sup> J.V. Pickstone, *Medicine and Industrial Society. A History of Hospital Development in Manchester and Its Region, 1752-1946* (Manchester, 1985), pp. 199-200.

<sup>37</sup> BCA, BMHW, HC/WH 1/10/5, Annual Report, 1904.

knew he could speak on behalf of the Medical Board in saying that they welcomed the severest criticism that would enable them to obtain the best possible results. Nevertheless, he cautioned against striving for the lowest possible figure as it was necessary to discriminate between the causes of death. Some deaths, such as acute general peritonitis were unrelated to surgery and had an extremely high mortality rate. Notwithstanding these risks, Taylor said that 'nothing should be done to discourage the surgeon in his attempt to save lives' and there was a need to speak now, as 'when they had the new building and more beds more of these cases were likely to occur'.<sup>38</sup> In his reply, Chamberlain said that if surgery was now possible on cases previously not thought feasible, then by all means they should operate with confidence. He pointed out that in the early years of the hospital the medical staff were undertaking operations considered by many at the time to be dangerous. The Management Board had been supportive then and he assured them that the Board would not criticise them unduly now. They recognized that the medical staff's one desire was to do their work in the best possible way and Chamberlain entirely agreed with the points Taylor had made, but criticism was necessary from time to time. For example, he observed that the deaths did not always occur in the most difficult cases; quite often the simplest cases were responsible for the high death rate. He noted that when he pointed this out, they sometimes discovered reasons related to the hospital itself. 'Hence, the importance of intelligent criticism and he hoped

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<sup>38</sup> Ibid.

that the intelligence of the lay man was as good as it could be allowing for their circumstances.<sup>39</sup>

Whilst the Governors undoubtedly had confidence in their surgeons they were keen to have an independent audit of the work of the hospital. There is no evidence to suggest that this was common practice at that time but it was entirely consistent with the ethos of the hospital. From the outset, the Governors were determined that the Charity was to be as well managed as any public institution in the town and as efficient as any commercial undertaking. No expense was to be spared that would contribute to the effectiveness of the medical treatment undertaken but they wanted to ensure that they were achieving the best possible results available, within the limits of medical knowledge at that time. From the time they had started the hospital, enquiries had been made from almost every other institution performing similar operations. Chamberlain thought this information was interesting and useful to the medical staff and the Management Committee alike; if other institutions could do better, then they should enquire as to the reasons.<sup>40</sup> What information they could glean from other hospitals usually confirmed that with regard to a low mortality rate, they were among the most successful of the institutions. Of greater concern, was the increasing time that women were waiting for admission to the hospital. One possible reason for this was that the medical staff were admitting women who perhaps should have been referred elsewhere. Thereby, in May 1906 the question of inviting some eminent surgeon, such as the President of the Royal College of Surgeons, to Sparkhill to undertake a clinical audit was discussed. The Medical Board

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<sup>39</sup> Ibid.

agreed in principle but thought that it better to have a surgeon with specialist knowledge of gynaecology. They suggested a surgeon from the Continent, for example, Dr Wertheim, who had recently invited Mr Taylor and Dr Edge to Berlin.<sup>41</sup> By way of compromise, it was agreed that Dr Alexander Simpson, a gynaecologist from Edinburgh, be requested to visit the hospital.<sup>42</sup>

Simpson subsequently visited the hospital on 27 February 1908 and wrote the following week to convey his pleasure at having been invited. Simpson particularly expressed his admiration for the new building; it had been well planned and provided all the up-to-date requirements and accommodation for patients. He acknowledged the worldwide reputation of the medical staff, referring to the important contribution that they had made to the history of surgery. He was also impressed with their efficient record keeping and warmly praised the nursing staff, especially the Matron, who appeared to be 'the embodiment of the very spirit one wishes to see reigning in such an institution'.<sup>43</sup> Much of his report, however, was directed towards the purpose of his visit, an independent audit of a selection of cases admitted to the hospital. He noted that in the reports for 1903, in three out of the eight fatal cases the patient had been operated on for diseases of the liver and stomach. Simpson said it was easy to understand that women suffering from 'gallstones and other liver troubles should come to the Institution on which Lawson Tait left his strong impress'.<sup>44</sup> He also noted that disease in the pelvic region was often complicated by renal trouble, or that a diagnosis could sometimes only be ascertained during an operative procedure. In addition, it was often the

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<sup>40</sup> Ibid., HC/WH 1/10/4, Annual Report, 1901.

<sup>41</sup> Ibid., HC/WH 1/2/4, Management Committee, 17 May 1906.

<sup>42</sup> Ibid., 1 October 1907.

<sup>43</sup> Ibid., 14 April 1908.



case that the patient requested to be treated by a particular doctor if he had previously operated on her for a gynaecological condition. Nonetheless, in the annual reports there were many cases of tumours or cysts of the breast that might well be given over to the surgical ward of a general hospital. It was cases such as these that added unnecessarily to the suffering of those awaiting admission.<sup>45</sup>

On a more encouraging note, Simpson spoke strongly in support of Professor Taylor's bid to introduce medical training at the hospital. He felt there was much to be gained from clinical teaching and it was vital that doctors should have some practical experience before they took responsibility for overseeing the health of women in the community. Simpson also said that in his experience instruction could be given without any distress to the patient; rather women often welcomed it. To be made the subject of a clinical demonstration was 'a sure guarantee to the hospital patient that her case would be carefully gone into and carefully managed throughout its course'.<sup>46</sup> Furthermore, clinical teaching was a constant source of encouragement and stimulation to the staff to keep abreast of the developments in medical science. At the time that Simpson had been approached by the Management Committee the introduction of medical training at the hospital had not been agreed. Professor Taylor had written in September 1907 requesting that the Board of Management permit pupils to attend during his operating lists. Taylor pointed out that, as Professor of Gynaecology at the University he was placed at a disadvantage by the fact that the Women's Hospital was not recognized for teaching purposes, particularly as the General Medical Council

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<sup>44</sup> Ibid.

was insisting that clinical or practical experience in gynaecology should be gained during medical training. The Management Board had in fact consented to Taylor's request and in November 1907, the University formally recognized the Women's Hospital for teaching purposes.<sup>47</sup> Taylor was not to benefit from the outcome of his efforts; after a period of poor health, he wrote to say that he must, with great regret, resign his position as honorary surgeon.<sup>48</sup> It was reported that Professor Taylor 'died peacefully at his home in Newhall Street, Birmingham on 3<sup>rd</sup> March 1910, at the age of 59 years'.<sup>49</sup>

At the time of Taylor's death, there were a number of matters under discussion, the most urgent of which was the provision of an isolation ward.<sup>50</sup> Mention has been made in Chapter One of the dangers caused by puerperal fever, notably in relation to the infectious nature of this condition. This had considerable financial and practical implications for the gynaecological service at Sparkhill. Puerperal fever posed a potential risk to other patients and to avoid this, adjacent beds had to be closed to isolate the infected patient. The staff were clearly relieved when it was proposed that an additional block should be built 'to take septic cases that would pose problems to other patients'.<sup>51</sup> It is interesting to note the different emphasis and terminology used to describe this ward. The Management Committee, perhaps mindful of the need to appeal to potential subscribers, reported that 'the ward for specially serious cases opened on 1 January 1910 and had already proved of

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<sup>45</sup> Ibid.

<sup>46</sup> Ibid.

<sup>47</sup> Ibid., 19 September 1907.

<sup>48</sup> Ibid., 23 June 1908.

<sup>49</sup> *Birmingham Post*, 5 March 1910.

<sup>50</sup> The issue of a Home for Dying and the future of the Maternity Hospital were also being considered. See Chapters 6 and 7.

<sup>51</sup> BCA, BMHW, HCWH 1/10/5, Annual Report, 1908.

great value in the treatment of cases for which it was provided'.<sup>52</sup> In contrast, the Medical Report for 1910 read as follows:

Margaret Ward opened at the beginning of the year and has since been fully occupied, with 125 patients treated there. It is a great source of satisfaction that we can now admit and treat septic cases without risk of infection to patients in adjoining wards.<sup>53</sup>

The cases seen on Margaret Ward were largely patients under the care of the Maternity Hospital and the work of the ward will be discussed in Chapter Seven. It is sufficient in the context of this chapter, to note that pressure was such that, within months of opening, there was an urgent need for more beds to be provided. The Management Committee authorized the sum of £1,500 to provide six additional beds, a patient's clothes room and a veranda to be erected at the end of the ward.<sup>54</sup> It was fortunate that the Committee agreed to fund this small extension as the area was utilized the following year to provide an additional operating theatre. This arrangement allowed surgery to be performed within the confines of the ward which greatly reduced the risk of cross infection.

This was particularly important in a hospital that dealt almost exclusively with acute surgical cases. Medical gynaecology, that is conditions that did not need surgical intervention, were managed in the out-patient department. The case notes of Mr John Hewitson for the year 1911 indicate that women attended with similar types of diseases to those admitted in the 1870s (discussed in Chapter One). The operating lists show a range of minor and major gynaecological procedures, such as dilatation and curettage, usually for

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<sup>52</sup> *Ibid.*, Annual Report, 1909.

painful periods, myomectomy for the removal of fibroids and abdominal hysterectomy, often performed for chronic pelvic inflammatory disease or ovarian cysts. There were also still cases of perineal tear or complete rupture of the perineum recorded. A number of women had acute pelvic inflammatory disease, often gonococcal or septic puerperal infection in origin, but tuberculosis was also found to be a causal factor, particularly in ovarian abscess. As in earlier years operations to repair a prolapsed uterus were common but this does not mean they were undertaken lightly. Rose, aged 48 years had been married for 19 years and had three children, the last one 8 years ago. She complained of a 'falling of the uterus' for the past 12 months. The prolapsed uteri did not go back when Rose was lying down but she said there was no pain just 'the discomfort of it between the thighs'. On examination, the cervix and the vaginal wall were found to be protruding outside the vulva and it was noted that it caused her great pain when the cervix was replaced. Rose had an anterior and posterior repair and amputation of the cervix. She was discharged from hospital 'cured' after 21 days.<sup>55</sup>

Aside from the gynaecological cases there were a number of major operations that would be classified as general surgery, usually for women with malignant disease. These included cancer of the bowel or the rectum and cancer of the breast. Notwithstanding Simpson's criticism of their practice, it had always been the policy of the hospital to accept women where the nature of the disease would cause embarrassment in the clinic of a general hospital. This particularly applied to diseases of the breast where early diagnosis might

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<sup>53</sup> Ibid., Annual Report, 1910.



be critical. It could be argued that this policy was justified. It is interesting to note more women came to the hospital in the early stages of carcinoma of the breast and these were thought to be the most suitable for surgery. Women were less likely to come to the hospital in the early stages of cancer of the cervix. We have discussed in earlier chapters the reluctance of women to undergo a vaginal examination and modesty has been posited as the reason for the delay in seeking treatment. A further explanation may be that there are few obvious signs of carcinoma of the cervix in the early stages and, as irregular bleeding (a symptom of the disease), commonly occurs in their late forties women may have assumed it was related to the change of life. Mary was just 41 years old when she went to the out-patient clinic complaining of 'flooding' at the time of her period during the past year which had got worse over the previous two weeks. Following the out-patient appointment the bleeding became severe and it was noted that she also had a very offensive discharge. Mary was immediately admitted for an exploratory operation where it was found that she had carcinoma of the cervix which had progressed to an advanced stage. She returned to theatre four days later and had a total abdominal hysterectomy and bilateral salpingo-oophorectomy (excision of uterus, fallopian tubes and ovaries), with removal of the top of the vagina.<sup>56</sup>

This last detail is significant as it suggests that the operation performed was a Wertheim's hysterectomy. As noted above, two surgeons from the hospital had been to visit Werthiem in Berlin in 1906 and it is probable that they discussed the operation he described at the meeting of the British

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<sup>54</sup> Ibid., HC/WH 1/2/5, Management Committee, 20 April 1910.

Medical Association (BMA), in 1905. The procedure is a serious operation in which not only the uterus and appendages are removed, but the connective tissue around the uterus and part of the vagina. It was a revolutionary procedure and signified the radical surgery that was one of the scientific developments in surgery in the late nineteenth and early twentieth centuries. As noted in Chapter Two, there was a long history of feminist opposition to the radical nature of gynaecological surgery and the mutilating effects of the operation attracted fierce criticism, notably from those within the social purity movement. A groundswell of anti-medical feeling had been generated amongst women in the late nineteenth century. This was a result of campaigns against the legal powers that medical professionals were acquiring to invade the integrity of the female body, through such legislation as the Contagious Diseases Acts and the Vaccination Acts.<sup>57</sup> Many of their arguments drew on the widespread female anxiety regarding male violence towards women and the purported disregard that doctors had for the modesty of women in 'so-called charitable institutions'.<sup>58</sup> As will be shown below, these arguments were used to support the need for women doctors and the founding of the Marie Curie Hospital. Nevertheless, it is crucial to our perception of medical practice in the early twentieth century to develop an understanding of surgical thinking at that time.<sup>59</sup> Historically, conservative surgery aimed to preserve the integrity of the body whilst the term radical was

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<sup>55</sup> Ibid., HC/W. 3/3/2, Case notes of Mr John Hewitson, 1911.

<sup>56</sup> Ibid.

<sup>57</sup> A.L. Scott, 'Physical Purity Feminism and State Medicine in Late Nineteenth-Century England', *Women's History Review*, 8:4 (1999), p. 628.

<sup>58</sup> Ibid., p. 629.

<sup>59</sup> G.H. Brieger, 'From Conservative to Radical Surgery In Late Nineteenth-Century America', in C. Lawrence (ed.), *Medical Theory, Surgical Practice. Studies in the History of Surgery* (London and New York, 1992), p. 217.

often used to signify merely an eagerness to operate. This new surgery arose out of the scientific developments in cellular pathology and bacteriology.<sup>60</sup> Henceforth, the emphasis was on the cultivation of the science of surgery as opposed to the mere art, which required little study and too often degraded surgery into little more than human butchery.<sup>61</sup> Gert H. Brieger has shown that during the later decades of the nineteenth century there was a gradual change from conservative to radical surgery. Careful diagnosis, aided by a fuller understanding of the underlying disease process and the prudent use of the knife, was seen to be compatible with the philosophy of true conservatism.<sup>62</sup>

Adherents to this new philosophy pointed to the advantages of radical surgery in the treatment of carcinoma of the cervix. Wertheim claimed 40 five-year cures out of every 100 patients, as against 10 or less obtained by simple abdominal or vaginal total hysterectomy. He also held that his operation was applicable to around 50 per cent of all cases as opposed to the 10 or 15 per cent which were the limit of the lesser procedures.<sup>63</sup> One area of concern was the high mortality rate; Wertheim reported 30 deaths in the first 100 operations he had performed, although when he read his paper at the meeting of the BMA he had reduced the rate to 20 per cent.<sup>64</sup> By 1926, Victor Bonney, one of the leading British gynaecologists of the inter-war years, had achieved a general mortality rate of 15.8 per cent but this was still regarded by opponents of surgery as unacceptably high.<sup>65</sup> By the 1920s the radical

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<sup>60</sup> Discussed in Chapter Three.

<sup>61</sup> Brieger, 'From Conservative to Radical Surgery', p.220.

<sup>62</sup> *Ibid.*, pp. 219-22.

<sup>63</sup> V. Bonney, 'Wertheim's Operation in Retrospect', *Lancet* (16 April 1949), pp.637-39

<sup>64</sup> *Ibid.*, p.637.

<sup>65</sup> *Ibid.*, p.638.



abdominal hysterectomy was the standard treatment for advanced carcinoma of the cervix, although many gynaecologists had doubts about submitting a patient to a 'prolonged and dangerous operation' which could not completely remove the disease.<sup>66</sup> As Bonney pointed out however, the only alternative at that time was to operate on 10 out of every 100 patients by one of the lesser operations, and leave the remaining women untreated.<sup>67</sup>

As indicated above, developments in scientific medicine, such as x-ray and pathology, put additional financial pressure on voluntary hospitals. Furthermore, costs had increased generally and in 1912 there was a budget deficit of £1,050.<sup>68</sup> The National Insurance Act (1911) was responsible for some of the additional expenditure; weekly contributions (4d from the employee, 3d from the employer and 2d from the state) were required from all wage earners with incomes under £160 a year. In return for these contributions wage earners, but not their families, were entitled to cash benefits in times of sickness, to the services of a general practitioner and to pharmaceutical benefits.<sup>69</sup> In practice, the National Insurance Act had little impact on the Women's Hospital, as few women were covered by the scheme. Nevertheless, medical staff and Governors shared the more general anxiety about the implications of the Act for the future of voluntary hospitals. These views were not shared by all parties; Herbert Martin did not think they were at risk and observed that, as with all public questions, there were pros and cons. The best judges anticipated that there would be less out-patient and more in-patient work because, 'with sick benefit, the poorer classes would be able to

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<sup>66</sup> O. Moscucci, 'The Ineffable Freemasonry of Sex: Feminist Surgeons and the Establishment of Radiotherapy in Early Britain', *Bulletin of the History of Medicine*, 81 (2007), p.141.

<sup>67</sup> Bonney, 'Wertheim's Operation', p.637.

<sup>68</sup> BCA, BMHW, HC/WH 1/10/5, Annual Report, 1912.



attend the illness when it came, instead of having to go on until they dropped as was the case in times gone by'.<sup>70</sup>

The Annual Report the following year confirmed his predictions. There had been a decrease in the number of out-patient attendances and an increase in the number of in-patients. As the in-patient work was more expensive, they also showed a larger deficit in the accounts. Of greater immediate concern to the hospital was the loss of their President. Arthur Chamberlain, whose health had been deteriorating for some time, died of cancer at his winter home in Ottery St Mary, Devon, on 19 October 1913.<sup>71</sup> The Lord Mayor said that the hospital had lost 'a great friend'; as he pointed out, 'they all knew how much he was to the hospital, in fact for a long time he was the hospital'.<sup>72</sup> As his colleagues acknowledged, Chamberlain was largely responsible for the foundation of the hospital and the success of the Institution owed much to the framework of governance that he had established. From the outset, Chamberlain laid great emphasis on the importance of audit through the collection of statistics to enable them to compare their work with that of similar institutions. When things were not going well he discussed the problem frankly with those responsible and it is a mark of the cordial relationship between Governors and medical staff that he was able to do this without rancour. Although there were occasional differences of opinion, there is no evidence of the power struggle that historians have reported elsewhere.<sup>73</sup> The medical staff were represented on all the committees of the hospital and it

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<sup>69</sup> D. Fraser, *The Evolution of the British Welfare State* (2nd ed.) (London, 1984), p.166.

<sup>70</sup> BCA, BMHW, HC/WH 1/10/5, Annual Report, 1912.

<sup>71</sup> Smith, 'Chamberlain'.

<sup>72</sup> BCA, BMHW, HC /WH 1/10/6, Annual Report, 1913.

would appear they had equal status to the lay members. For example, Christopher Martin and Mr J. Furneaux Jordan were both Chairman of the House Committee for a number of years. Their involvement in the running of the hospital had the advantage of giving the Medical Board a clear understanding of management issues such as finance. The benefit of this was found when the hospital was in a serious financial position in 1944; the Management Committee received a letter from the medical staff informing them that 'they would not be claiming their honorarium for the year'.<sup>74</sup> The minutes of their meetings suggest that there was mutual respect between lay and professional staff and their shared concern for the health of women underpinned the strength of that relationship. As the Chairman noted, Chamberlain had 'fought the battle for the women of Birmingham... at a time when that cause was not so much to the front as it was now'.<sup>75</sup> This was the common bond between them; in their tribute the medical staff stated that 'they wished to place on record the debt the hospital owed to Mr Arthur Chamberlain and the loss sustained by Birmingham women in the death of a true friend'.<sup>76</sup>

At the Annual Meeting the following year it was announced that Mrs John Feeney had agreed to be President of the Hospital. This was not the first occasion on which a woman was elected; that distinction belonged to the Countess of Dudley, who was elected in 1894 and served until 1899. That was thought to be the first appointment of a lady President in the Midlands

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<sup>73</sup> L. Granshaw, *St Mark's Hospital, London: A Social History of a Specialist Hospital* (London, 1985), Waddington, *Charity and the London Hospitals*, Pickstone, *Medicine and Industrial Society*.

<sup>74</sup> BCA, BMHW, HC/WH 1/5/3, Medical Board, 7 November 1944.

<sup>75</sup> Ibid. HC/WH 1/10/6, Annual Report, 1913. It is probable that Nettlefold was referring to the work *Maternity*, recently published by the Co-operative Guild. Cited Chapter Four.

and, if a lesser person than Arthur Chamberlain (who succeeded her) had not been available doubtless the practice would have continued. In formally proposing Mrs Feeney's election, John Nettlefold said that it seemed particularly appropriate for a woman to be President as it typified the interest that women in all walks of life took in the work of the hospital. He was particularly pleased that a Birmingham woman had been appointed, 'a woman who had lived among them, who had shared their interests, and knew their ways'.<sup>77</sup> Birmingham born, Christine Feeney had links with many of the city's philanthropic institutions and movements. Aside from her support for Birmingham Museum and Art Gallery which had been a particular interest of her late husband, Feeney took a keen interest in the movement for the provision of parks and open spaces in the district and was a generous subscriber to the city's voluntary hospitals.<sup>78</sup>

Christine Feeney had previously donated money to Margaret Ward and, although childless herself, took a special interest in the work of the Maternity Hospital. Thus, she was familiar with the work of the Institution but despite everyone's assurance that she was the most suitable person for the post Feeney expressed her nervousness when appointed. She said it was very difficult to 'fall into the shoes of a man who had for forty years been the cornerstone of the Institution', but if they would give her a little time and a little patience 'she would try to take a woman's part and a woman's interest in a woman's hospital which concerned her own sex'<sup>79</sup>. In the early years of her

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<sup>76</sup> Ibid.

<sup>77</sup> Ibid.

<sup>78</sup> Christine Feeney was the widow of John Feeney, formerly proprietor of the *Birmingham Post* and *Birmingham Mail*, who died in 1905. She was trustee of the John Feeney Charitable Trust. *Birmingham Post*, 13 June 1928.

<sup>79</sup> BCA, BMHW, HC/WH 1/10/6, Annual Report, 1913.

Presidency, Feeney was to lose the services of another long standing member of the staff. It would appear that a letter of resignation had been received from the Matron, Miss Richmond in September 1915, but this was not minuted at that time. It is possible that the Governors had asked her to reconsider this. Since Richmond had been appointed there had been an improvement in the management of the Institution which the Governors attributed to her. The most notable change was the fall in the mortality rate. Under her watchful eye, in the years 1908 to 1912 inclusive they had achieved an average death rate of 2.3 per cent compared to the previous average of 6.4 per cent.<sup>80</sup>

This is not to suggest that Feeney lacked female company at the hospital; aside from the women Governors, the Institution continued its custom of employing female dispensers and maintained its policy of employing women doctors where ever possible. The records indicate that the majority of junior medical staff were female and when appropriately qualified, women were appointed to senior posts. For example, Hilda Shufflebothan (later Professor Dame Hilda Lloyd Rose) graduated from the University of Birmingham's Medical School in June 1916 and joined the staff of the Women's and Maternity Hospitals as Resident Surgical Officer that same year. She subsequently obtained her FRCS in 1920 and was appointed to the consultant staff at the Women's Hospital in 1921. A further new appointment was that of Miss Margaret Cuss who commenced her duties at the hospital in February 1916, at a time when the hospital was beginning to feel the effects of war.<sup>81</sup> Whilst the difficulties the hospital experienced cannot be compared with those

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<sup>80</sup> Ibid., HC/WH 1/10/4, Annual Report, 1902, HC/WH 1/10/6, Annual Report, 1913.



suffered by many institutions, they did impact on the daily lives of the hospital.<sup>82</sup> The biggest problem was the shortage of nursing staff; as discussed in the previous chapter, the hospital became responsible for taking in its own probationers in 1878 and had since developed a three-year programme of nurse training. There had been little difficulty in recruiting probationers, but after the outbreak of war they had found it increasingly hard to attract nursing staff, a problem that was widespread.

Nationally there was a shortage of nurses as women took advantage of the opportunities for other employment created by the war. In towns and cities across Britain, women filled a wide range of jobs left vacant by men called up for the armed services. Others, inspired by the idea of military nursing, had trained as civilian nurses in the hope of being called to battle at time of war.<sup>83</sup> Until the late 1890s, the female nursing service was a very limited one. On the eve of the Boer War there were still only 72 army nurses but after the war they began to enrol in their hundreds.<sup>84</sup> Anne Summers has seen this phenomenon as a reflection of women's wider engagement in public life; one aspect of this was a 'desire to participate in the affairs of the whole nation, especially as represented by the Army and the Empire'.<sup>85</sup> Women as well as men were part of the vast movement by civilians to volunteer their services in aid of the war effort, as shown by the 50,000 women who joined the Voluntary Aid Detachments (VADs) between 1909 and 1914.<sup>86</sup> By early 1912 there

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<sup>81</sup> Ibid., HC/WH 1/2/7, Management Committee, 22 December 1915.

<sup>82</sup> See Abel-Smith, *The Hospitals*, Chapter 6, for an account of the difficulties experienced by voluntary hospitals during the First World War.

<sup>83</sup> A. Summers, *Angels and Citizens: British Women as Military Nurses 1854-1914* (London, 1988) (revised edition London, 2000), p.xiv.

<sup>84</sup> Ibid., p.xiii.

<sup>85</sup> Ibid., p.xix.

<sup>86</sup> Ibid., p.187.

were 300 regular nurses in the QAIMNS, 3,000 in the Territorial Force Nursing Service (TFNS); and a further 26,000 VADs, civilian women who were prepared to assist the territorial medical service in a national emergency.<sup>87</sup> The training these women received varied enormously but usually amounted to little more than a couple of hours of ward work a week. Notwithstanding their lack of formal training, they soon acquired the title 'nurse' and the uniforms they wore resembled those of a professional nurse. Whilst the nursing community did not want to criticize the VADs at a time of war, there was a growing resentment of these 'amateur nurses' who were seen to diminish the status of the profession. There was also a concern that these semi-trained women would be used to replace professional nurses who were called away on territorial duty, or in the case of a national strike.<sup>88</sup>

Undoubtedly, these concerns gave weight to the argument for a Register of Nurses, which gained prominence after the war. The 30-year battle for Registration, well documented by historians of nursing, is beyond the scope of this thesis; it is sufficient for our purpose to note that the Nurse's Registration Act finally received Royal assent in December 1919.<sup>89</sup> Of greater importance, in the context of this thesis, is the subsequent establishment of the General Nursing Council (GNC) in 1920. Aside from maintaining the statutory Register, it was the duty of the Council to approve training schools and here small voluntary hospitals feared that they would be disadvantaged. Prior to

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<sup>87</sup> Ibid., p.217.

<sup>88</sup> Ibid., p.225.

<sup>89</sup> The standard text on the history of the battle for registration is B. Abel-Smith, *A History of the Nursing Profession* (London, 1960), chapters 4-7, see also A. Bradshaw, *The Nurse Apprentice 1860-1977* (Aldershot and Burlington, USA, 2001), A. Witz, *Professions and Patriarchy* (London and New York, 1992), chapter 3, Witz analyses the campaign for registration as a feminist demand for self-government as an alternative to the putative 'subjection' of nurses.

registration, nurses were issued with a certificate from their training institution but the quality of training varied widely; although it was generally of a high standard in the London teaching hospitals, it was usually regarded to be of poorer quality in the smaller hospitals. Henceforth, there was to be a national examination and only those who passed this examination were to be admitted to the register.<sup>90</sup> The Council had determined that nurses who had trained for two years in specialist hospitals were eligible for examination for the general part of the Register, provided they undertook a subsequent two years in a General or Poor Law Hospital. The House Committee at the Women's Hospital noted that the two years training in the specialist hospital had to include the subjects contained in the first year of the GNC syllabus, in addition to their own specialist subjects. It was thought that extra lectures might be needed but it transpired that the assistance of an external tutor was only required for elementary physics, all other subjects could be done by the staff.<sup>91</sup> This left the problem of finding another hospital that would affiliate with them to allow their probationers to complete their training. Initially, an affiliation scheme was agreed with Lincoln County Hospital, whereby they would take probationers from the Women's Hospital at the end of their second year to complete their training for the Register. They had a similar arrangement with the Derby Union until 1928, when the Union was recognized as a training school.<sup>92</sup> Thereafter, 123 nurses went on to take general training in a variety of hospitals, including St Bartholomew's in London. The establishment of the National Health Service in 1948 brought the

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<sup>90</sup> Abel-Smith, *History of the Nursing Profession*, pp. 61-62.

<sup>91</sup> BCA, BMHW, HC/WH 1/3/9, House Committee, 19 September and 17 October 1922.

<sup>92</sup> *Ibid.*, 15 March 1923, HC/WH1/3/10, 18 January 1927.



amalgamation of the Birmingham teaching hospitals into a single teaching hospital, the United Birmingham Hospitals.<sup>93</sup>

Thus the hospital successfully negotiated one of the major reforms of the post-war period, the implementation of the national programme for nurse training, whilst maintaining the independence it cherished. The post-war crisis in the financial position of the hospital was the more difficult problem to resolve; in common with the majority of voluntary hospitals, the Sparkhill hospital had a deficit, which amounted to £4,333 19s 7 1/2d in 1919.<sup>94</sup> This was due to a number of factors; post-war inflation had raised in-patient treatment costs, nursing salaries had increased and there was a fall in charitable contributions. The position was to improve over the next decade or so; as with other voluntary hospitals, there was an increased demand for private beds. For example, in September 1925 it was noted that of the 220 patients who had been admitted that month 58 had been private patients.<sup>95</sup> By 1927, the Management Committee were able to report that 'considerable relief had been obtained from the difficult financial position'. In part this was due to 'the strenuous efforts to take the greatest possible care over their expenditure', but also there had been an increase in public support.<sup>96</sup> In particular, the special appeal fund made on behalf of the Maternity Hospital (discussed in Chapter Seven) had raised over £5,500 towards the liquidation of the building debt. In addition, there was 'the remarkable efforts made by the Maternity Hospital to obtain life Governors' which had resulted in the

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<sup>93</sup> S. Wildman, 'The Development of Nurse Training in the Birmingham Teaching Hospitals, 1869-1957', *International History of Nursing Journal*, 7:3 (2003), p. 61.

<sup>94</sup> BCA, BMHW, HC/WH 1/10/7, Annual Report, 1919.

<sup>95</sup> *Ibid.*, HC/WH 1/3/10, House Committee, 15 September 1925.

<sup>96</sup> *Ibid.*, HC/WH 1/2/11, Management Committee, 31 December 1932.



realisation of a further £4,000.<sup>97</sup> By the 1930s, the Institution was also beginning to see the benefit of investment funds, which had added £5,000 to the income of the hospital in that year, so, although the deficiency at the end of the year was £1,000 more than the previous year, the situation was better than it appeared.

Furthermore, there was a substantial increase in income from contributory schemes; for example, in 1919 the Birmingham Hospital Saturday Fund gave a generous donation of £2,000 which was a substantial increase over the previous year. The Fund had been able to do this 'owing to the workpeople of the city doubling their weekly contribution in order that additional help might be given to the hospitals'.<sup>98</sup> The increase in contributions (which was advisory, not compulsory) was in part a recognition of their difficulty but also in the cause of promoting 'co-operative hospitals'. By 1891, the Saturday Fund had developed as an independent organization, which espoused the ideals of 'Constructive Socialism'. Their journal, *Forward*, described this as 'an attempt on the part of the labouring classes to reorganise society by their own efforts without regard to the wealthier classes'.<sup>99</sup> The opening of the Fund's first convalescent home in Llandudno in 1892 was one example of this; another important initiative was the decision to support public hospitals. Birmingham Poor Law Guardians were amongst the first to provide separate, purpose-built infirmaries, opening Dudley Road Infirmary in 1889.<sup>100</sup> As will be shown in Chapter Seven, there was a degree of co-operation between the municipal

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<sup>97</sup> Ibid., HC/WH 1/10/8, Annual Report, 1927.

<sup>98</sup> Ibid. HC/WH 1/10/7, Annual Report, 1919.

<sup>99</sup> M. Gorsky, J. Mohan and T. Willis, 'A Splendid Spirit of Co-Operation: Hospital Contributory Schemes in Birmingham Before the National Health Service', in J. Reinartz, *Medicine and Society in the Midlands: 1750 - 1950* (Birmingham, 2007), pp.172-73.

<sup>100</sup> Ibid., p.173.

and voluntary hospitals, particularly with regard to the admission of maternity patients. This arrangement anticipated the recommendations of the Cave Committee, set up in 1921 to consider the post-war crisis in the finances of voluntary hospitals. The ensuing Voluntary Hospital Consultative Committee recommended the rationalization of hospital services and the development of hospital contributory schemes.<sup>101</sup> This reflected the trend in Birmingham where there was local pressure for the rationalisation of local charity through an organized city-wide contributory scheme. Within this context, the Birmingham Hospital Contributory Association (BCHA) was established in January 1928, to provide a central funding body for the city's hospitals.<sup>102</sup> The chairman of the Management Board, Bertrand Ford and the Hon. Secretary Mr Aston were both on the committee of the BCHA and this was to prove beneficial to the hospital. Preparing his Annual Report for 1932, the Treasurer said that there had been an increase in the work of both hospitals that year and yet the expenditure was practically identical. These facts, an increase in work, an increase in income and yet no increase in expenditure, were due to the very hard work of the staff and the effort of the Management Committees but also the very large income from the contributory scheme. It was thanks to the efforts of Mr Aston and his staff that 'the hospital got all that it was possible to obtain from the scheme'.<sup>103</sup>

Notwithstanding the success of the contributory scheme this did not entirely resolve the problem; the total revenue of the two hospitals during 1929 was £32,625 which was £724 less than in the previous year and more

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<sup>101</sup> S.Cherry, 'Beyond National Health Insurance. The Voluntary Hospitals and Hospital Contributory Schemes: A Regional Study', *Social History of Medicine*, 5 (1992), pp.458-59.

<sup>102</sup> Gorsky et al., 'A Splendid Spirit of Co-operation', pp.174-75.

<sup>103</sup> BCA, BMHW, HC/WH 1/2/11/, 31 December 1932.

than accounted for by the drop of £1,300 in private subscriptions.<sup>104</sup> As Sir Gilbert Barling pointed out, 25 per cent of the patients in the voluntary hospitals in Birmingham were not connected with either the Hospital Saturday Fund or the contributory scheme. This meant that the cost of their treatment was met mainly out of private subscriptions, which were 'as necessary as ever they were in the past'.<sup>105</sup> In addition, there was the cost of purchasing more technically advanced equipment; for example, x-ray equipment for the hospital had been purchased in 1927, but money had not been available to install it. Thanks to a legacy left by the late Mrs Feeney and a donation from the John Feeney Charitable Trust, the new x-ray department was completed in 1929 and in tribute, named after their late President.<sup>106</sup> Another addition to the hospital was a new pathological department where it was anticipated that considerably more research work could be done into areas such as cancer and infertility; however, perhaps the most important development of that year was the decision to purchase radium. This necessitated the hospital selling £5,000 worth of securities to purchase the radium, but it was considered that 'the money would be well spent if only a few cases were relieved or cured'.<sup>107</sup>

The ability of radium to destroy malignant tumours was first discovered by Pierre Curie in the early years of the twentieth century. Its value in the treatment of carcinoma of the cervix was soon recognized; Robert Abbe of New York is thought to be the first person to successfully treat carcinoma of

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<sup>104</sup> Ibid., HC/WH 1/10/8, Annual Report, 1929.

<sup>105</sup> Ibid.

<sup>106</sup> Ibid., Annual Report, 1927 and 1929.

<sup>107</sup> Ibid.



the cervix uteri by these means in 1903.<sup>108</sup> The systematic trial of radium therapy, however, was largely undertaken in France and Sweden, both countries having established a radium Institute, the Radiumhemmet in Sweden (1910) and the Institute of Radium in Paris (1919). In England radiotherapy was not widely used until the 1920s; the first deep therapy apparatus was installed at the West London Hospital in 1923 and another was established at Guy's Hospital in the same year. The more extensive use of radium followed an address given by Heyman to the Royal Society of Medicine in 1929 and the subsequent discussion on the merits of the Stockholm method, as used by Heyman.<sup>109</sup> It is probable that the publicity this meeting attracted prompted the vice-chancellor to establish a committee to consider the use of radium in Birmingham. In April 1929 it was reported at the Medical Board that Barling had asked the hospital to appoint a member to the committee and clearly they were enthusiastic. At the same meeting it was resolved to ask the House Committee to secure a supply of radium, for use at the Women's Hospital.<sup>110</sup>

Notwithstanding the anticipated benefits of the treatment, radium and x-ray therapy posed potential problems for both patients and staff.<sup>111</sup> Nevertheless, the disadvantages had to be weighed against the fact that cancer of the cervix had been the leading cause of female cancer death in Britain from the 1840s and at that time no cure had yet been found.<sup>112</sup> Treatment with radium

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<sup>108</sup> F. Cook, 'The Progress in Radio-Therapy in Gynaecology', in J. M. Munro Kerr, R.W. Johnstone and M. H. Phillips (eds), *Historical Review of British Obstetrics and Gynaecology 1800-1950* (Edinburgh and London, 1954), pp.383, 385.

<sup>109</sup> Ibid., p. 386.

<sup>110</sup> BCA, BMHW, HC/WH 1/5/3, Medical Board, 12 April 1929.

<sup>111</sup> See C. Murphy, 'A History of Radiotherapy to 1950: Cancer and Radiotherapy in Britain, 1850-1950', Chapter 5, PhD thesis, University of Manchester, 1986, on the dangers of radiation.

<sup>112</sup> Moscucci, 'The Ineffable Freemasonry of Sex', p. 141.



appeared to offer an alternative to surgery; indeed it was widely believed that the application of radium offered the greatest hope in 'advancing the treatment of cancer of the cervix'.<sup>113</sup> It was also hoped that a less interventionist approach might encourage women to seek help in the early stages of the disease. As noted above, women had an intense dislike of the intimate examination necessary to diagnose the disease and this was widely blamed as the cause of their delay in seeking treatment.<sup>114</sup> Many women were also worried about the mutilating effect of surgery and this fear was heightened by the amount of criticism such surgery received. The eugenicist doctor Caleb Saleeby condemned the 'monstrously selfish' and arrogant surgeons who continued to operate for carcinoma of the cervix and argued that 'wherever radium is available, the ghastly and deadly operation of panhysterectomy should be condemned as malpraxis'.<sup>115</sup>

Within this climate, proponents of radium found a ready audience. Women doctors drew attention 'to the value of radiotherapy as a humane, woman-friendly alternative to the mutilating surgery practised by male surgeons'.<sup>116</sup> The Medical Women's Foundation were enthusiastic about the possibilities of radiotherapy and readily responded when Dr Helen Chambers suggested that a body of medical women might co-operate in a clinical trial to assess the value of radium therapy in the treatment of carcinoma of the cervix, as an alternative to Wertheim's hysterectomy.<sup>117</sup> Initially, the treatment was carried out in individual hospitals but it was soon felt that the work should be centralized and its scope extended. Subsequently, the Marie Curie Hospital

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<sup>113</sup> *Lancet*, 12 May 1928, p. 973.

<sup>114</sup> Moscucci, 'The Ineffable Freemasonry of Sex', p. 157.

<sup>115</sup> *Ibid.*, p.161.

<sup>116</sup> *Ibid.*, p.157.

was opened on 16 September 1929.<sup>118</sup> This centralization of services allowed clinical data to be obtained in sufficient quantities to be of statistical value which added greatly to the reputation of the hospital and demonstrated the benefits of having a Centre designed and equipped for the purpose.<sup>119</sup> In addition to the clinical advantages of a specialist centre, there was also a degree of self-interest. As Moscucci has noted, this women-run hospital provided an opportunity for medical women to enhance their own employment opportunities, at a time when sexual discrimination still placed serious constraints on their careers.<sup>120</sup>

Whilst space was not available to develop a specialist centre at the Women's Hospital they were determined to achieve the best results attainable within their resources. As a first step, it was agreed that surgeons from the hospital should visit established centres in Europe to learn how radium was being used in gynaecological cases. Subsequently, Mr McMillan went to Paris whilst Mr Barney Adshead visited Stockholm and evidently they benefited from the experience. At the September meeting of the Medical Board it was agreed to ask the House Committee to provide ultraviolet lights, 140 mg of radium and special applicators to handle it. There was also a lengthy discussion concerning the use of radium at the hospital; it was decided that there would be a common waiting list for treatment and an agreed admission procedure that would be overseen by Mr Aston. Margaret Ward, designed to enable patients to be nursed in isolation, was considered to be the most appropriate ward in which to nurse the patients and a special staff nurse was

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<sup>117</sup> *Ibid.*, pp. 156-57.

<sup>118</sup> R.J. Dixon, 'The Marie Curie Hospital 1925-68', *British Medical Journal*, 16 November 1968, pp. 444-46.

<sup>119</sup> Moscucci, 'The Ineffable Freemasonry of Sex', p.160.

to be engaged to care for the radium patients. To facilitate research, a protocol for the follow-up of radium cases was agreed; in addition, a register of patients treated was maintained and a statement regarding the radium work was included in the annual report.<sup>121</sup>

Table 4

PATHOLOGICAL DEPARTMENT

*Number of specimens examined –*

Pathological (Histology)	2,440
Bacteriological	1,306
Biochemical	636
Haematological	288
Vaccines	19
	<hr/>
	4,689
	<hr/>
Number of Ascheim-Zondek Tests	57
Number of Post-mortems	19

‘Pathological examination’ refers to material removed at operations.  
‘Bacteriological examination’ includes urine, blood, faeces, pus, sputum, cerebro-spinal fluid, throat swabs, eye swabs, urethral and cervical swabs.  
‘Biochemical examination’ refers to chemical investigation of urine, blood, fluid and faeces.

‘Haematological examination’ refers to blood counts, blood groupings and compatibility tests for transfusions.

The junior technician, Mr G Harper, was called up for service with the RAMC at the outbreak of the War.

C W Taylor  
Pathologist

Although these arrangements served their purpose in the short term it put further pressure on the beds needed for cases of puerperal fever; furthermore, there was a problem in the general wards of patients being

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<sup>120</sup> Ibid., p.158.  
<sup>121</sup> BCA, BMHW, HC/WH 1/5/3, Medical Board, 12 April 1929, 3 June 1929.

discharged too early after their operations. It was evident the hospital needed additional accommodation; to resolve the problem, a new floor was built above Margaret Ward, with wards for radium cases and convalescent patients.<sup>122</sup> It was also considered necessary to reassess the provisions they had made for radium treatment with a greater emphasis on research and the importance of histology. The advice of Dr Redman was sought to see if anything further could be obtained from the pathology service. She duly submitted a list of the necessary equipment that she required for the research work. The provision of deep x-ray equipment was more difficult; as noted above, the equipment was expensive and it rapidly depreciated in value as new methods were introduced and the usual solution was to centralize the apparatus.<sup>123</sup> Accordingly, the Medical Board agreed to accept an offer from the Skin Hospital to use their deep x-ray apparatus in the short term.<sup>124</sup> A greater priority was the appointment of a medical officer to take charge of all radium work. It was agreed that the radium officer should have undertaken specialist training and gained experience, preferably abroad. Subsequently Miss Beatrice Wilmott was appointed to take over the radium work.<sup>125</sup>

By the mid-1930s, treatment by radium only or radium and x-rays had become the treatment of choice in cases of carcinoma of the cervix at the Women's Hospital. In the years 1935 (October to December) to 1939, a total of 203 patients were treated with radium only or radium and x-rays compared with 16 patients treated by hysterectomy and radiotherapy. In cases of carcinoma of the uterus the differential is not so marked; 32 patients received

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<sup>122</sup> Ibid., 12 January 1934.

<sup>123</sup> 'The Coming of Radiology', *Lancet*, 4 January 1930.

<sup>124</sup> BCA, BMHW, HC/WH 1/5/3, Medical Board, 4 April 1936, 3 June 1937.

<sup>125</sup> Ibid., 12 January 1934, 27 April 1934, 18 September 1935.



radium only or radium and x-rays compared to 26 treated by hysterectomy and radiotherapy. The percentage survival rates are not easily compared with those reported by Bonney or those achieved at the Marie Curie Hospital, as their approach to treatment was different. Furthermore, the results of the Women's Hospital do not cover the accepted standard of a five-year period. Notwithstanding these difficulties it is possible to draw some conclusions; the small number of cases, and the lower percentage survival rates in patients following hysterectomy and radiotherapy suggests that radical surgery was undertaken when involvement of adjacent glands was suspected. Regarding their clinical practice more generally, it would appear they had the respect of their peers. In 1938 Professor Sir Beckworth Whitehouse reported that the Gynaecological Visiting Society wanted to visit the hospital to see a programme of operations; furthermore, Beatrice Willmott was chosen as the official delegate from Birmingham to attend the International Cancer Conference in Atlantic City in September 1939.<sup>126</sup>

The outbreak of World War Two halted further developments, both in plans for a new x-ray department and operating theatre which were delayed until after the war and in the treatment of carcinoma of the cervix by radium therapy. Work in this field was halted almost immediately as at the outbreak of war the radium was stored in a borehole at the General Hospital and was not available for use again until the last week in December. As a result, only 56 new cases of malignant disease were treated in 1939, a much smaller number than usual.<sup>127</sup> The following year air raids over Birmingham necessitated the closure of the hospital for a month; it was subsequently

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<sup>126</sup> Ibid., 23 August 1938, 11 May 1939.

reopened with a reduced number of beds for urgent cases and emergency admissions. In addition, a house was taken in the relatively safe area of Lichfield so that patients could be transferred, as soon as their condition was stable; this made beds available for further urgent cases to be admitted to Sparkhill. The auxiliary hospital, known as Hammerwhich, also allowed radium therapy to be brought back into use and by March 1941 it was possible to commence surgery at Hammerwhich.<sup>128</sup> This was welcomed by the medical staff and Governors; a total of 1987 operations had been performed in 1939 (see Table 5 below) and beds needed to be filled as soon as they became empty, to avoid lengthy waiting times for patients.<sup>129</sup> This was particularly important from May 1944, when the Ministry of Health informed the hospital that 50 beds were to be emptied immediately and kept vacant until further instructions were received. The hospital was finally notified in January of the following year that a date would soon be fixed when the emergency medical service would relinquish the beds. The estimated cost to the hospital from the loss of admissions was £7,000 per annum.<sup>130</sup>

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<sup>127</sup> Ibid., HC/WH 1/13/6, Annual Report, 1939.

<sup>128</sup> Ibid., HC/WH 1/5/3, Medical Board, 2 December 1940, 10 March 1941, 31 March 1941.

<sup>129</sup> Ibid., HC/WH 1/13/6, Annual Report, 1939.

<sup>130</sup> Ibid., HC/WH 1/5/3, Medical Board, 15 May 1944, 2 January 1945.

**Table 5**  
**Statistical Tables of the Women's Hospital 1939**

**Out-Patients**

<b>Month</b>	<b>No. of new cases suitable</b>	<b>Number of cases rejected</b>	<b>Number of old cases</b>	<b>Total Attendances</b>
January	404	1	685	1090
February	367	-	639	1006
March	403	-	652	1055
April	294	-	581	875
May	410	-	671	1081
June	416	-	652	1068
July	388	-	616	1004
August	278	3	516	797
September	250	-	599	849
October	373	-	598	971
November	336	-	547	883
December	189	-	419	608
<b>Totals...</b>	<b>4108</b>	<b>4</b>	<b>7175</b>	<b>11287</b>

**In-Patients: Cases Admitted**

<b>Month</b>	<b>Paying</b>	<b>Free</b>	<b>Total</b>
January	38	181	219
February	40	165	205
March	41	176	217
April	38	166	204
May	37	189	226
June	38	187	225
July	44	181	225
August	28	138	166
September	21	149	170
October	28	176	204
November	27	163	190
December	19	125	144
<b>Totals....</b>	<b>399</b>	<b>1996</b>	<b>2395</b>

Notwithstanding these difficulties, further clinical innovations had been introduced, notably in the field of infertility. New understanding of the sex hormones and endocrine system from the late 1920s resulted in a surge of interest in reproductive physiology, with a number of papers and articles being

produced. Of particular interest was the possible therapeutic use of hormone preparations in the treatment of sterility.<sup>131</sup> Although it is not mentioned in the records, it is possible that, as a teaching hospital the Institution participated in the Therapeutic Trials Committee, set up by the Medical Research Council to develop trials of the efficacy of new medicines.<sup>132</sup> Certainly patients were receiving hormone injections for infertility in the out-patients department in 1938 and subsequently fertility clinics were opened at the General Hospital. Dr Taylor, the pathologist had a special interest in artificial insemination of hormones (between husband and wife), and ran the male sterility clinic, whilst Miss Shotton, who specialized in the treatment of involuntary childlessness, had established a clinic to investigate the causes of sterility in women.<sup>133</sup>

The first post-war medical report had positive news; the new x-ray equipment, planned before the war, was purchased in January 1946 and the pre-war system of 40 and 50 mg radium needles had again been adopted. Nonetheless, gynaecological surgery still accounted for most of the work at the hospital and despite having expanded almost threefold to 140 beds, at the end of 1946 there were 501 patients on the waiting list.<sup>134</sup> It is fortunate, therefore, that the hospital continued to provide gynaecological care to the women of Birmingham after the advent of the National Health Service in 1948. This was not a foregone conclusion; the regional boards were not in favour of small specialist hospitals and posed a particular threat to women-only institutions. As Mary Ann Elston has noted, the NHS brought a formal ending to single-sex medical education and restriction of medical appointments by

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<sup>131</sup> N. Pfeffer, *The Stork and the Syringe. A Political History of Reproductive Medicine* (Cambridge, 1993), provides a detailed analysis in Chapter 3.

<sup>132</sup> See *Ibid.*, pp. 76-78 for details of the MRC's trials.

<sup>133</sup> BCA, BMHW, HC/WH 1/5/3, Medical Board, 12 February 1945.



sex; thus, women-only institutions could no longer base their claims on *de jure* discrimination.<sup>135</sup> Gradually, hospitals staffed by medical women closed or merged with other institutions; nevertheless, a number of women-run hospitals did survive including Garrett Anderson's New Hospital for Women and the Edinburgh Hospital for Women and Children established by Jex-Blake.<sup>136</sup> The Women's Hospital retained its teaching role within the University of Birmingham Medical School and became one of the constituent hospitals of United Birmingham Hospitals.

The aim of this chapter has been to explore the governance of the hospital and how the Management Board responded to the challenges of the inter-war years. We have also seen that developments in medical science had significant financial implications and that income and expenditure occupied the minds of those charged with the management of the hospital. The formal management of the Institution was, however, only one part of the Governor's role. Of equal importance, was monitoring the day-to-day running of the hospital and the oversight of patient care. As will be shown in the following chapter, the Governors maintained regular contact with their patients and were familiar with the circumstances of the lives of working-class women in Birmingham. It was this knowledge and understanding of the difficulties many working-class families experienced during the inter-war years that made them determined to provide ongoing care. This took the form of convalescence, to ensure women made a full recovery after discharge or for those whom

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<sup>134</sup> *Ibid.*, 12 February 1945, 14 May 1945, 11 March 1946.

<sup>135</sup> M.A. Elston, 'Run by Women, (mainly) for Women', in A. Hardy and L. Conrad (eds), *Women and Modern Medicine* (Amsterdam and New York, 2001), p.98.

<sup>136</sup> *Ibid.*, p.76, table 4.1.

recovery was not possible, palliative care. It is to these matters that we turn to in the following chapter.

## Chapter 6

### *Caring for Women in the Inter-war Years*

#### *Convalescent Homes and the Taylor Memorial Home of Rest*

In the previous chapter we considered the more formal role of Governors in the management of the Institution but, as noted in previous chapters, the welfare of the patients was always of prime importance to them. The Governors visited the wards and departments regularly and spoke to the women to learn of their concerns. It was through her visits to the hospital that Mrs Lakin Smith identified the need for a period of convalescence after discharge.<sup>1</sup> Subsequently, convalescent care was started in 1883 and had become an integral part of patient care. It will be demonstrated below that the need for ongoing care and support for women continued throughout the inter-war years. The aim of this chapter is to examine how convalescent care was provided in the first half of the twentieth century. Nationally there was concern about the health of women in the early decades of the century. As will be discussed in the following chapter, early government initiatives focused on maternal health and the care of infants but by the 1930s, the health of the mother, as the central figure in family life was also a matter of concern. We have some contemporary evidence from the working classes of the circumstances of their lives, for example the letters published by Llewelyn Davies on behalf of the Women's Co-operative Guild (discussed in Chapter Four).<sup>2</sup> Other useful sources are the oral histories collected by Elizabeth Roberts and the health enquiry undertaken in the 1930s which forms the basis

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<sup>1</sup> See Chapter Four.

of Elizabeth Spring Rice's book. This work is particularly helpful; of the 1,250 replies received the largest number, 246, came from women living in Birmingham.<sup>3</sup> These works provide the background which informs our understanding of the need for convalescent care, a need that was recognized by many contemporary observers. A further initiative of the Charity was the establishment of a Home for the dying, the Taylor Memorial Home of Rest. We trace the efforts made towards providing palliative care for terminally ill women from the foundation of the Home, through the difficult years of World War Two and on to the last meeting of the Board of Governors in 1948. We begin by considering the origins and development of the convalescent movement during the nineteenth and twentieth centuries.

The movement for the establishment of convalescent homes has been associated with the Manchester surgeon, John Robertson. Robertson advocated convalescence at the coast, both on economic and health grounds. At that time nearly three quarters of the population of Manchester required medical assistance every year; moreover, he held that for many there could be no improvement without getting patients away from the unfavourable conditions in the cities; the remedy lay in a period of convalescence on the coast.<sup>4</sup> The value of the sea air and bathing was first recognized by the medical profession in the middle of the eighteenth century, largely as a result of a paper written by Dr Richard Russell, on the 'Uses of Seawater in

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<sup>2</sup> M. Llewellyn Davies, *Maternity. Letters from Working Women Collected by the Women's Co-operative Guild* (1915) (republished, London 1978).

<sup>3</sup> E. Roberts, *A Woman's Place. An Oral History of Working-Class Women 1890-1940* (Oxford and Cambridge, Mass., 1984). M. Spring Rice, *Working-Class Wives. Their Health and Conditions* (1939) (paperback edition, London, 1981).

<sup>4</sup> R.F. Fox, W.E.B. Lloyd, 'Convalescence on the Coast', *Lancet*, 2 July 1938, pp. 37-39.



Diseases of the Glands'.<sup>5</sup> In the ensuing years the invigorating effect of sea air, especially for the recovery of delicate children became generally recognized and the Royal Sea Bathing Infirmary at Margate (founded in 1796) became the first of a number of 'marine' hospitals established on the coast.<sup>6</sup> Nevertheless, the benefits of sea air and bathing were largely the prerogative of the rich. Those most in need, such as 'the delicate children and invalids of the cities (or) the crowded and debilitated factory workers, seldom saw the sea or the country'.<sup>7</sup> Robertson argued that the sick poor and disabled deserved and required, as much as the wealthy, the means of recovery. It was an argument that was well received; as shown in Chapter One of this thesis, industrialization caused a number of problems in the new manufacturing cities, notably in the area of public health. What was true of Manchester was true in other industrial areas and in the latter decades of the nineteenth century a large number of convalescent homes, were opened in seaside resorts.<sup>8</sup>

An alternative location was the countryside, an option favoured by Florence Nightingale who was a leading supporter of convalescent homes. Nightingale wrote on the importance of convalescence in a variety of books and other publications and was widely quoted in medical journals. For example, the *British Medical Journal* noted in 1864 that the hospital authorities in Winchester had followed her recommendation that 'convalescent patients should not be cared for in hospital convalescent wards but in

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<sup>5</sup> R. Russell, *Dissertation on the Uses of Seawater in Diseases of the Glands* (London, 1750). Cited *ibid*, p.37.

<sup>6</sup> J. Robertson, *Edinburgh Medical Surgical Journal* (1937), pp.48, 326. Cited *ibid*, p. 37.

<sup>7</sup> *Ibid*.

<sup>8</sup> *Ibid.*, p.38.

Convalescent Homes away from cities'.<sup>9</sup> This advice was adopted by a number of voluntary hospitals who subsequently established convalescent institutions, either by the seaside or in the neighbouring countryside. In part, this was a means of freeing up beds for subscribers. Jenny Cronin has suggested that the Royal Infirmary Edinburgh was the first to do this when it opened Costorphine Home in 1867.<sup>10</sup> Alice Beale freely admitted that a similar policy operated at the Women's Hospital. Speaking at the opening of the new Convalescent Home in 1904, Beale said that any one who had experience of looking after women following serious surgical operations knew how important it was that they should have a satisfactory period of recovery. This was particularly true for their patients as most of the women coming in to this hospital returned to homes where, aside from the housework, they were sometimes compelled to do factory work as well. From experience, they had learnt that a period of two to three weeks rest was necessary before women were fit to return to their usual occupation. 'Unfortunately, the hospital had literally hundreds of cases waiting and their suffering would be increased if they had to wait even longer.'<sup>11</sup> The Convalescent Home was a means whereby this could be avoided. Nevertheless, neither finance nor the waiting list was the overriding consideration. As noted in Chapter One, the Governors were quick to intervene if they thought patients had been discharged too early and, as will be shown below, the practice of Governors making regular visits to the Homes continued in the inter-war years. In their opinion, convalescent

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<sup>9</sup> *British Medical Journal* (hereafter *BMJ*), 14 May 1864, p.550. Cited J. Cronin, 'The Origins and Development of Scottish Convalescent Homes, 1860-1939', PhD Thesis, University of Glasgow, 2003, p.55.

<sup>10</sup> *Ibid.*, p.24.

<sup>11</sup> *Ibid.*

homes should not be used as an excuse to discharge the patient before they were fit to be released.

Contemporary commentators were clear that there was both a moral and a medical interest in promoting the merits of convalescent homes. The *Lancet* reported at length on the resolution proposed by Lord Cranborne, to enlarge Mrs Gladstone's Convalescent Home at Snaresbrook, founded in connection with the London Hospital. Medical staff and philanthropists pointed to the many obstacles that prevented the poor from returning to full health after they had been discharged from hospital. The patient was forced to return to a home in the 'back slums', totally unsuitable for him 'while he was himself still more unfit to return to his usual labour'.<sup>12</sup> The consequence was often chronic illness which in turn resulted in destitution. It was reported that the idea of the Snaresbrook Institution occurred to Mrs Gladstone because she learnt from her work with the poor in a cholera district of London of the debilitating effect of illness on the working classes. As the article noted, the observations of Mrs Gladstone could be confirmed by every doctor in the city; if convalescent homes were necessary in provincial towns they were still more necessary in London. The editor was particularly glad to recommend Mrs Gladstone's Institution because it served the poor in the slums of the East End of London. Furthermore, it was free to the patient and admission was not determined by recommendation, as was the usual practice but by a committee of subscribers, who were 'expected to give preference to the worst cases'.<sup>13</sup>

Similarly, most of the convalescent homes established in the nineteenth century were linked to voluntary hospitals and, aside from freeing up beds,

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<sup>12</sup> 'Convalescent Homes', *Lancet*, 30 November 1867, pp. 679-80.

they were seen as necessary to ensure the treatment was ultimately successful. Thereby, they were viewed as primarily medical institutions and, as with those associated with the Women's Hospital, they were an integral part of the hospital system. The Charity had taken the opportunity to include a new 12-bed convalescent home in the plans for the new hospital in 1903.<sup>14</sup> The additional accommodation helped to relieve pressure within the hospital as patients could be transferred to a convalescent home far sooner than they could be discharged home. Nonetheless, it would appear that there was a genuine need among the working classes in the late nineteenth and early twentieth centuries for a period of rest, to enable men and women to regain their health before they returned to work. The Birmingham Hospital Saturday Fund was an early advocate of convalescent care and opened their first convalescent home in Llandudno in 1892.<sup>15</sup> Convalescent homes were also founded by the Co-operative Society, friendly societies and in industry as work-place schemes.

Stephen Cherry has estimated that by 1911 the voluntary hospitals provided only one third of convalescent beds in Britain, with the remaining two thirds being sponsored outside the hospital system.<sup>16</sup> Cherry does not note the sponsors of these homes but among the reasons that have been posited is that convalescent homes offered an effective means of returning employees to economic productivity. This argument is supported by the fact that

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<sup>13</sup> Ibid., p.680.

<sup>14</sup> Birmingham City Archives (hereafter, BCA), Archives of The Birmingham and Midland Hospital for Women (hereafter, BMHW), HC/WH 1/10/5, Annual Report 1904.

<sup>15</sup> M. Gorsky J. Mohan and T. Willis, 'A Splendid Spirit of Co-Operation: Hospital Contributory Schemes in Birmingham Before the National Health Service', in J. Reinarz (ed.), *Medicine and Society in the Midlands* (Birmingham, 2007), p.172.

<sup>16</sup> S. Cherry, *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge, 1996), p.47.



occupational schemes were usually founded by employers, as in the mining industry but sometimes convalescent homes were founded by workers themselves.<sup>17</sup> For example, a railway employee, John Edward Nicholls, was largely responsible for the establishment of the first Railway Convalescent Home in 1901. Nicholls had for many years been associated with the work of friendly societies, particularly with the provision of convalescent care for the working classes. Thereby, he was aware that that financial hardship meant that sick men all too frequently returned to duty before they were really fit to work.<sup>18</sup> Having secured the support of the philanthropist J. Passmore Edwards and the help of a group of railwaymen willing to become Trustees, the group set about the detailed planning of the project. The foundation stone of the first Railwayman's Convalescent Home at Herne Bay was laid on 1 May 1899.<sup>19</sup>

There is evidence to suggest that women were equally supportive of convalescent care. Tom Devine has noted that the main work of the Scottish Co-operative Women's Guild which before the First World War, was 'by far the most important working-class women's organization' in Scotland was concerned with raising funds for convalescent homes.<sup>20</sup> Devine has argued that the Guilds, with their emphasis on 'domestic' issues such as cookery and dress-making could be seen as reinforcing the 'role of women as wives and mothers, whose place was very much in the home'.<sup>21</sup> Eleanor Gordon has acknowledged that Guild members 'operated within the accepted sphere of

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<sup>17</sup> Cronin, 'Convalescent Homes', p.120.

<sup>18</sup> J. L. Salmon, *A Proud Heritage. The Story of the Railway Convalescent Homes* (London, 1954), pp. 17, 23-25.

<sup>19</sup> *Ibid.*, p.18.

<sup>20</sup> T. M. Devine, *The Scottish Nation 1700-2000* (London, 2000), p.541.

<sup>21</sup> *Ibid.*

women by focusing upon raising money to furnish bedrooms and fundraising through such traditional methods as the bazaar'.<sup>22</sup> Nevertheless, Gordon has observed that 'most socialist women tended to emphasize the particular contribution they could make to public life because of their role as wives and mothers and the innate qualities of womanhood'.<sup>23</sup> Further, through their involvement with the Guild women gained experience of organizing events and the confidence to develop their skills in public speaking.<sup>24</sup> It also developed their confidence to work within a wider social environment. It would appear that these women expected some input into the running of the Homes as a report of the opening ceremony at one Home noted that the women had placed many obstacles in the way of Trustees. They had also asked for a number of conditions to which the Trustees could not agree.<sup>25</sup> A feature of the Co-operative Convalescent Homes was the emphasis on their recreational benefits. It was reported that at the opening of Ardmhor House in 1914 'expressions of delight were heard on all sides, one lady going so far as to say that it was not a convalescent home at all, but a hydropathic'.<sup>26</sup> This was indicative of the rest home model of convalescent care that emerged in the early decades of the twentieth century.

It is possible this development influenced the gift of a country house at Cleeve Prior by Leopold Myers in 1913, for the use of convalescing patients. The Home was to be known as the Gertrude Myers Convalescent Home, in memory of his wife. Gertrude Myers had been a Governor at the Women's

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<sup>22</sup> E. Gordon, 'Women's Spheres', in W.H. Fraser and R.J. Morris (eds), *People and Society in Scotland, Vol II, 1830-1914* (Edinburgh, 1990), p. 231.

<sup>23</sup> *Ibid.*, pp.231-32.

<sup>24</sup> Devine, *Scottish Nation*, p.541.

<sup>25</sup> Cronin, 'Convalescent Homes', pp.121-22.

<sup>26</sup> *Scottish Co-operator*, 6 May 1914, pp.445-47. Cited *ibid.*, p.122.

Hospital for many years, as had Leopold Myers and they had both visited the wards and out-patient department on a regular basis. Thereby, it is probable from his conversations with patients that Myers would have been aware that the daily lives of working-class women were very hard. We know from contemporary accounts that their days were spent between 'washing, ironing, cleaning, shopping and cooking' and some women had a full-time job as well as a home to run.<sup>27</sup> The gift was particularly welcomed by the Charity as the house was well equipped and beautifully situated with 2 1/2 acres of ground.<sup>28</sup> The Home could accommodate 12 patients and in its first year of operation over 100 women had been admitted, with an average length of stay of three weeks.<sup>29</sup> The Annual Report in 1919 noted the Gertrude Myers Home was of the great benefit to patients particularly those who required an extended period of rest. Women were not transferred to the Home until they were medically fit and simply required a period of rest, good food, and fresh air. As discussed in Chapter Two, a similar regime underpinned the practice at the Edinburgh Hospital for Women and Children and was often shown to be sufficient to restore women to health.<sup>30</sup> In contrast, the Park Road Convalescent Home in Birmingham was able to take patients who otherwise would have had to stay in hospital longer. Its proximity to the hospital meant that medical assistance was available if needed. Furthermore, a trained nurse had always been employed to take charge of the Home, usually a nurse from the hospital and additional trained staff were employed in later years. As we have seen in earlier chapters, the Home was so conveniently situated that

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<sup>27</sup> Roberts, *A Woman's Place*, p.8.

<sup>28</sup> BCA, WHB, HC/WH 1/10/6, Annual Report, 1912.

<sup>29</sup> *Ibid.*, Annual Report 1913.

there was a tendency for the medical staff to discharge patients earlier than the Governors thought fit. As was their practice in the earlier years, Governors monitored this on their visits to the Home; for example, in March 1926 they sent a detailed list of cases they considered unsuitable to the Chair of the Medical Board.<sup>31</sup> The pressure was finally relieved in 1934, when an additional ward was built for convalescing patients.<sup>32</sup>

The Convalescent Homes became increasingly important to the hospital in the inter-war years. In 1927, Park Road admitted 306 patients, compared to 277 the previous year; the comparative figures for the Gertrude Myers Home were 314 against 161.<sup>33</sup> In part, this was due to the general poor health of women which delayed their post-operative recovery. The degree of ill health among working-class women was confirmed by the Women's Health Enquiry Committee (1933), formed to investigate the general conditions of health among women, in view of the findings of the Departmental Committee on Maternal Mortality and Morbidity (1932) and the reports by the Government Actuary (1930 and 1932), which showed an increase in claims for benefit under the National Health Insurance Acts.<sup>34</sup> The areas of enquiry were: the incident and nature of general ill health among working-class women; its possible causes and how far women observed the basic rules of health and hygiene. The Committee collected information from 1,250 women from different geographical districts, social conditions and occupations.<sup>35</sup> The questionnaire was divided into two sections; the first being objective questions

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<sup>30</sup> E. Thomson, 'Women and Medicine in late Nineteenth and Early Twentieth Century Edinburgh: A Case Study', PhD Thesis, University of Edinburgh, 1998.

<sup>31</sup> BCA, BMHW, HC/WH 1/3/10, House Committee, 16 March 1923.

<sup>32</sup> Ibid., HC/WH 1/5/3, Medical Board, 12 January 1934.

<sup>33</sup> Ibid., HC/WH 1/10/8, Annual Report, 1927.

<sup>34</sup> Spring Rice, *Working-Class Wives*, p.21.



regarding social conditions such as housing, occupation, income etc. The second part dealt with health and was designed to provide information on the nature of the illness, including minor ailments and relevant questions such as diet and rest.<sup>36</sup> The ailments most commonly reported were: anaemia, 558 cases; headaches, 291 cases; constipation, 273 cases and rheumatism, 258 cases. Gynaecological problems were reported by 191 women plus a further 203 cases in which there appeared to be evidence of it but no professional diagnosis had been made. Carious teeth were reported by 165 women and varicose veins, ulcerated legs etc. were mentioned by 101 women who said that they had 'suffered acutely or been really crippled by such complaints'.<sup>37</sup> Only those cases where the diagnosis could be verified were included in the analysis.

Many of these conditions were thought to be under reported in that women looked upon them as minor disorders to which they had become accustomed. There was also a perception that women accepted a degree of ill health as inevitable. For example, Mrs A. of Birmingham was a 30-year-old married woman who had 10 children. When asked if she normally 'felt fit and well' she replied 'Fair' although she suffered from 'swollen legs and veins' and 'great weariness and headaches'.<sup>38</sup> The results of the questionnaires were analysed to establish the relationship between poor health and housing conditions, income, number of pregnancies and age in relation to four groups of women: those with apparently good health, indifferent health, bad health

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<sup>35</sup> Ibid., pp.21-22.

<sup>36</sup> Ibid., pp. 22-24.

<sup>37</sup> Ibid., p.37.

<sup>38</sup> Ibid., p.36.

and women with very bad health.<sup>39</sup> The findings of the Women's Health Enquiry Committee suggest that there had been little improvement in the lives of working-class women since the publication of *Maternity* in 1915.<sup>40</sup> Aside from the lack of ante-natal and post-natal care (discussed in the following chapter), two significant causes of ill-health were housing and nutrition.

We learnt in Chapter One of the problems of insanitary housing in Birmingham in the latter decades of the nineteenth century. Little progress had been made before the First World War and in 1918, there were still about 200,000 people housed in back-to-backs, over 42,020 houses had no separate water supply, sinks or drains and 58,028 houses had no separate W.C.<sup>41</sup> It would be misleading to suggest too bleak a picture of Birmingham during the 1930s. Birmingham did not suffer unemployment to compare with that of the industrial cities of the North. Further, Eric Hopkins has shown that death rates in Birmingham fell overall although there was a good deal of variation from Ward to Ward. While the average death rate for the city in 1936 was 11.5 per cent it was significantly higher in the thickly populated Central Wards, the highest being St Mary's at 15.7 at per cent.<sup>42</sup> Hopkins has argued that the most striking improvement in Birmingham was the decrease in infant mortality rates: in 1901-05 they averaged 157; by 1930-39 it had fallen to 64.1.<sup>43</sup> After the war, efforts were made by the Corporation to tackle the problem of insanitary housing and new municipal estates were developed on the outskirts of the city centre. Hopkins has estimated that about 8,000 homes

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<sup>39</sup> Ibid., p.211, appendix 4.

<sup>40</sup> Llewellyn Davies, *Maternity*.

<sup>41</sup> E. Hopkins, 'Working Class Life in Birmingham Between the Wars, 1918-1939', *Midland History*, XV (1990), p.137.

<sup>42</sup> Ibid., p.136.

<sup>43</sup> Ibid., pp.135-36.

were demolished in the heavily populated Central Wards in the years 1930-38. Nevertheless, in 1935 there were still 51,794 houses without a separate W.C.<sup>44</sup> Thus, in spite of slum clearance there remained much substandard housing, particularly in the Central Wards and in 1938 the Medical Officer of Health estimated that 17,500 houses were unfit for human habitation.<sup>45</sup>

Another major problem was overcrowding; a Birmingham woman described how she had to share a room with her grandparents, at a time when her grandfather was dying from cancer. The woman recalled how she would lay awake at nights listening to him choking, until he died when the girl was 18 years old. She moved into digs at the age of 23 years and remembered the glorious feeling of having a room to herself. The woman said that she would never forget her own experience and was determined that her children would not suffer the same.<sup>46</sup> Even if the accommodation was not overcrowded, there was the problem of sharing amenities. A young Birmingham mother with one baby had two comfortable rooms but had to share the cooking facilities and sink in the kitchen downstairs with other occupants of the house. As with the lady mentioned above, she complained bitterly about the lack of privacy.<sup>47</sup> A new council house was not always the answer, especially if the family's income varied a great deal, as it often did. For example, a Birmingham woman had several grown-up children at home and, although their cottage was small and without any conveniences, it was only 5/- per week to rent. The woman explained that it she could not risk renting a better

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<sup>44</sup> Ibid.

<sup>45</sup> Ibid., p.138.

<sup>46</sup> Spring Rice, *Working-Class Wives*, p.132.

<sup>47</sup> Ibid., pp.139-40.

house as she was never sure how much money was coming in each week.<sup>48</sup> Many women were in a similar situation; houses were more spacious on the new municipal estates but the rents were higher and beyond the income of labourers. As Asa Briggs has pointed out, the Council used the same principles in choosing its tenants as private landlords did; that is, you had to show that you could afford the rent. A man with a wife and three children was only accepted for a three bed-roomed house if he had a minimum income of 70s a week.<sup>49</sup> Hopkins has argued that this was a policy decision, suggesting that 'only the better paid were offered the chance to move, because the City Council wanted the first generation of council house tenants to be reliable and respectable'.<sup>50</sup>

A further complaint was that the estates were lonely places to live. In addition, the move away from the city centre also often meant the loss of a woman's part-time job'.<sup>51</sup> This had considerable implications for a family; women played an important role in the workplace and in 1931 accounted for 35.13 per cent of the city's workforce, compared to an average of 13.7 per cent for England and Wales as a whole.<sup>52</sup> A high percentage of these were married women who had continued to work after the war. As with the rest of the country, Birmingham suffered periods of acute recession in the inter-war years particularly during the early 1930s. Barry Hills has noted that it reached an average of 17.7 per cent in 1931, with a recorded peak of 75,039.<sup>53</sup> It is

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<sup>48</sup> Ibid., p.148.

<sup>49</sup> A. Briggs, *History of Birmingham, Volume II, Borough and City 1865-1938* (London, 1952), pp.234-35.

<sup>50</sup> Hopkins, 'Working Class Life', p.142.

<sup>51</sup> Ibid., p.139.

<sup>52</sup> B.K. Hill, 'Women and Unemployment in Birmingham 1918-1939', *Midland History*, XXV11 (2002), pp. 131-45.

<sup>53</sup> Ibid., p.131.



probable that these statistics understate the real level of unemployment. As Noel Whiteside has pointed out, the changes to unemployment benefit in 1931 and 1934 were particularly hard on female claimants. Under the 1931 Anomalies Act, 'a married woman was disqualified from all benefit unless she could show a reasonable expectation of obtaining insurable employment'.<sup>54</sup> Thus many women failed to register as they had no financial incentive to sign on. Furthermore, from 1931 the total household resources of the long-term unemployed, including the earnings of children or the lodger's rent, were taken into account when determining the right to benefit.<sup>55</sup> The system was administered by the local Public Assistance Committee and there were wide variations in the way the regulations were enforced. Birmingham relief agencies were particularly harsh; the Court of Referees rejected one in three cases altogether and by 1931 had rejected 94.8 per cent of the claims by married women.<sup>56</sup>

As has been indicated above, many working-class households in Birmingham were dependent on two wages coming in and the large-scale unemployment of married women is a possible reason for the significant levels of poverty in the city. Hill has shown that women turned to washing and charring to supplement the relief whilst others turned to the pawnbroker in the hope that things would one day get better.<sup>57</sup> Even on the new council estates there was evident poverty, as shown by the level of undernourishment revealed in a study of nutrition and the family carried out on the Kingstanding

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<sup>54</sup> N. Whiteside, *Bad Times. Unemployment in British Social and Political History* (London 1991) p.82.

<sup>55</sup> *Ibid.*, p.81.

<sup>56</sup> Hill, 'Women and Unemployment', pp. 138-39. Rotherham gave the full rate of assistance in 98 per cent of cases. Birmingham refused any assistance to 35 per cent of cases. Whiteside makes a similar point, *ibid.* pp.81-82.

estate in 1939. The survey sought to establish the minimum standard of spending on food necessary to maintain adequate health using the British Medical Association (BMA) minimum diet scale of 1933, and compared the balance of housekeeping money available after deductions were made for essential items such as rent, fuel, lighting and clothing. The survey was carried out at a time when there was virtually full employment.<sup>58</sup> As may be expected, the larger the family the more difficult it was to feed them adequately and in those families with four or more children over 85 per cent were on or below the BMA's Minimum Standard of Sufficiency.<sup>59</sup> For the entire population of the estate, 31 per cent of families were below the sufficiency line and some 60 per cent of children under 14 (about 8,150), were on or below the borderline.<sup>60</sup>

The figures in the Kingstanding survey reflected the national picture; as the Women's Health Enquiry Committee noted, it had been demonstrated by whatever standard of measurement adopted that a significant proportion of the population was 'too poor to buy enough of the kind of food necessary for the maintenance of sound health'.<sup>61</sup> This assessment was confirmed by the results of the Enquiry; in only a handful of the 1,250 household surveyed would the income have been sufficient to purchase what was required to meet basic nutritional needs.<sup>62</sup> Mrs G. from Newcastle, for example, was 29 years old and the mother of three children, the youngest a baby of four months. Her husband was out of work when she was pregnant and Mrs G. found it

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<sup>57</sup> Ibid., p.141.

<sup>58</sup> Hopkins, 'Working Class Life', p.144.

<sup>59</sup> *Annual Report of the Birmingham Schools of Medical Officer*, 1932. Cited *ibid.*, pp. 144-45.

<sup>60</sup> Ibid., p.145.

<sup>61</sup> Spring Rice, *Working-Class Wives*, p.155.

<sup>62</sup> Ibid., p.156.

impossible to get proper food. Her diet was 'almost entirely bread and butter and tea with potatoes or mince meat or pudding at dinner time'<sup>63</sup> (emphasis in the original). Even in the South East, generally considered to be less affected by the Depression, life was uncertain. A countrywoman in Sussex could not get enough nourishing food for herself and three young children when her husband was unemployed and admitted that sometimes she went without things herself.<sup>64</sup> This was not unusual; Health Visitors confirmed that if any one went short it was usually the mother. Nevertheless, there were some women able to provide good food for their family on very little money. Mrs D. of Birmingham had two children and managed to feed the family on a budget of 15/-per week; she had a substantial cooked breakfast, meat or fish and vegetables for dinner followed by steamed pudding.<sup>65</sup>

Mrs D. had been a cook before marriage and undoubtedly used the skills she had thus acquired; however, she was an exception to the norm. It is likely that the Governors were fully aware of the difficulties their patients faced at home. As noted in Chapter Two, many of the women connected to the hospital belonged to women's organizations in Birmingham and those who joined the hospital in later years were similarly inclined. For example, Lady Steel-Maitland, who was president of the Institution in the years 1933-36, was also Honorary Treasurer of the National Council for Women.<sup>66</sup> Thereby, as well as establishing the Convalescent Homes the Women's Hospital appointed a social worker and after-care worker to visit women at home to check on their progress after discharge and see if they needed any additional

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<sup>63</sup> Ibid., p.158.

<sup>64</sup> Ibid., p.159.

<sup>65</sup> Ibid., p.166.

help. In 1939 the after-care worker visited 1,340 patients in their homes. It was found that very often the women's diet was insufficient and help was given to provide extra food with the help of the Samaritan Fund.<sup>67</sup> Notwithstanding this support, there remained a substantial need for convalescent care. The number of patients admitted to Park Road Convalescent Home in 1939 was 493, 437 of these benefiting from the vouchers from Contributory Schemes.<sup>68</sup>

Inevitably there were those patients for whom recovery was not possible yet it was unlikely they could be cared for properly at home. It had been recognized for some time that a small Home should be started for those patients who had to leave the hospital uncured and were not likely to live many months'.<sup>69</sup> The need for institutional provision for the 'respectable poor', whose disease was of an incurable nature, was increasingly being recognized in the late eighteenth and early nineteenth centuries. Between 1879 and 1905, five Homes were established in London with 'the intention of providing a place of peace and comfort for the dying poor'.<sup>70</sup> However, the movement was not widespread and no such institution had been established in the Midlands. At the time of Professor Taylor's death, a general wish had been expressed to commemorate his contribution to the hospital. A Home for the Dying was thought to be an appropriate memorial, as it would be carrying on the work in which Taylor took an interest. It was proposed to start in a small

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<sup>66</sup> BCA, BMHW, HC/WH 1/2/11, Management Committee, 21 January 1933, 26 February 1935.

<sup>67</sup> Ibid., HC/WH 1/2/11, Management Committee, 26 of February 1935, HC/WH 1/10/9, Annual Report, 1939.

<sup>68</sup> Ibid.

<sup>69</sup> Ibid., HC/WH 1/2/5, Management Committee, 11 January 1910.

<sup>70</sup> C. Humphreys, 'Waiting for the Last Summons: the Establishment of the First Hospices in England 1878-1914', *Mortality*, 6:2 (2001), pp.146-66.



way and establish a Home to accommodate five patients, 'whose condition was such that the curative agencies of the hospital could do nothing further for them'.<sup>71</sup> A small house was taken in Park Road, adjacent to the hospital; the rent was £26 per annum and it was estimated that the total cost of maintaining six beds would be under £300 per annum.<sup>72</sup> It was suggested that they should try 'to obtain six ladies or gentlemen to give a donation of £380 each, which would bring in £25 per annum, half of the yearly cost per bed, for 20 years'.<sup>73</sup> A small charge would also be made to patients which, it was estimated, would bring in a further £50 a year.

The medical staff gave this initiative their wholehearted support and issued a statement to launch the appeal. It read:

At the Women's Hospital, Sparkhill, patients suffering from internal malignant disease can in many instances be practically restored to health by operation; but, on the other hand, there are cases in which we find upon surgical examination that the malady has become too advanced for successful treatment, and that there only remains a few weeks or months of life to such women. *Where and how are they to pass this period of suffering?* They are too ill to live alone, and if relatives exist, these usually consist of persons with young families dwelling in crowded houses entirely unfit for the reception of cases of hopeless and lingering disease. Thus, the horror of the situation is great. The Hospital cannot afford to keep

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<sup>71</sup> BCA, BMHW, HC/WH 1/2/5, Management Committee, 11 January 1910.

<sup>72</sup> Ibid., The Taylor Memorial Home of Rest (hereafter, TMH), HC/WH 1/13/3, General Committee, 4 May 1910.

<sup>73</sup> Ibid., HC/WH 1/2/5, Management Committee, 11 January 1910.

them; (but) there is no acknowledged "Home" for such patients in the Midlands.<sup>74</sup>

The Taylor Memorial Home of Rest Committee also received considerable support from a number of influential lay people, notably Sir Arthur Steel-Maitland, MP for the Erdington division of Birmingham, who agreed to be President of the proposed institution. Steel-Maitland was at the start of what was to prove to be a distinguished political career and worked with both Neville and Austin Chamberlain in government.<sup>75</sup> As a young man he had shown a deep interest in social welfare and was a member of the Poor Law Commission, 1906-07.<sup>76</sup> Thus, he had a wide knowledge of the social circumstances of the poor and was aware that 'the average workhouse infirmary was not the place to lightly suggest to many of those deserving and self respecting poor, although it had to be the resort of the really destitute'.<sup>77</sup>

Steel-Maitland chaired the meeting to launch the appeal, held at the Council House on 20 April 1910. He said 'Birmingham has gained a reputation of being one of the foremost cities in the Kingdom in regard to the thorough manner in which the sick and helpless members of the community (are) cared for'.<sup>78</sup> Thus, he was confident that the present appeal would meet with a generous response. Steel-Maitland was also able to give an account of

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<sup>74</sup> Ibid.

<sup>75</sup> Elected Conservative MP for East Birmingham in January 1910 Steele-Maitland became the first person to hold the post of Conservative Party chairman in September 1911. In 1917 Steele-Maitland became joint Parliamentary Under-Secretary at the Foreign Office and Parliamentary Secretary to the Board of Trade and in 1924 he was appointed by Baldwin as Minister of Labour. He was particularly concerned by the problem of unemployment and worked hard to achieve a constructive relationship between employers and the employees. Steele-Maitland's main legislative achievement as Minister of Labour was the 1927 Unemployment Insurance Act. E.H.H. Green, 'Maitland, Sir Arthur Herbert Drummond Ramsay-Steele- (known as Sir Arthur Steel-Maitland)', [www.oxforddnb.com/articles/36/36263-article.html](http://www.oxforddnb.com/articles/36/36263-article.html), accessed 4 May 2007.

<sup>76</sup> *The Times*, 1 April 1935.

<sup>77</sup> *Evening Dispatch*, 23 April 1910.

the progress made since the Annual Meeting, when it was first proposed to formulate the scheme. He reported that Dr Mary Sturge had thrown herself wholeheartedly into the work and said that it was largely due to her enterprising spirit that the idea had taken shape. A provisional committee had been founded and the appeal had met with substantial success. Mrs William Cadbury had offered a donation of £500; Mrs Christopher James had donated 100 guineas and a number of others had promised annual subscriptions of £20.<sup>79</sup> Thus, the appeal had got off to a good start but it was suggested that further help could be given to the movement by gifts of furniture, linen etc. or by offering to take charge of collecting cards.

The Women's Hospital was not in any way responsible for the management of the Home, a point that Christopher Martin emphasized, perhaps to reassure subscribers that the hospital would not be taking on additional financial liabilities. He described it rather as 'a rounding off of the work of the hospital'.<sup>80</sup> Nonetheless, the Governors and staff gave the Home a good deal of help; the Matron, Miss Richmond was particularly supportive and the nursing staff made the whole of the house linen, curtains etc, in their spare time. The senior sister at the hospital took charge of the Home and the medical staff of the Women's Hospital continued to oversee the care of the patients.<sup>81</sup> At the first Annual Meeting, it was reported that the five beds had been continuously occupied. Christopher Martin was able to confirm that the Home was providing a much needed service and was treating exactly the

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<sup>78</sup> Ibid.

<sup>79</sup> Ibid.

<sup>80</sup> *Daily Post*, 13 June 1910.

<sup>81</sup> BCA, BMHW, TMH, HC/WH 1/13/4, Annual Report, 1910.

cases that it was intended for.<sup>82</sup> Typical patients included Mrs A. 35 years, who presented with 'hopeless, inoperable cancer'. She had six children, the eldest a boy of 12 years and the youngest a child of 11 months. Mrs A. had no relatives able to look after her and the burden appeared to fall on her eldest son. While she was in the Home, the boy managed the house and the younger children; he also did the shopping and cooked his father's meals. On Saturday evenings, he came to sit with his mother and tell her what he had been doing during the week. Another lady, Miss B., a spinster aged 40 years, also suffering from cancer, was found in lodgings, very much in debt and with no friends to care for her. Miss C., described as a 'very old woman' with inoperable cancer, was more fortunate. Although also unmarried she was able to pay a little towards her keep and was 'most thankful to find a home where she could be properly nursed and cared for'.<sup>83</sup>

In total, 10 patients had been admitted during the first six months; seven patients died and two were discharged, after some temporary improvement.<sup>84</sup> There was considerable pressure on the Home; the beds were filled as soon as they became vacant but many more patients had to be refused; clearly there was a need for larger premises. In September 1911, the Management Committee of the Women's Hospital reported that they had succeeded in purchasing Showell Green House for the sum of £3,000, which would be let to the Taylor Memorial Home of Rest Committee at a rent of £40 per annum.<sup>85</sup> The building first needed to be adapted to accommodate 20 patients and it was also necessary to install electric bells and paint the exterior of the house.

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<sup>82</sup> Ibid., and HC/WH 1/13/3, General Committee, 4 May 1910.

<sup>83</sup> Ibid., HC/WH, 1/13/4, Annual Report, 1910.

<sup>84</sup> Ibid.

<sup>85</sup> Ibid., BMHW, HC/WH 1/2/5, Management Committee, 12 September 1911.



A guiding principle of hospice care is the recognition that 'people approaching the end of life are still part of life, brothers and sisters of us all, going through what may well be the most important part of their lives'.<sup>86</sup> Thus, the quality of life is very important and the Home was planned in much the same way as a family home. Much thought was given to the internal decoration, comfortable furniture and the important finishing touches such as pictures for the walls and china tableware; these items were normally provided by Governors and subscribers as gifts. By January 1912, furnishing of the Home was almost complete and the staff moved in to put the finishing touches.<sup>87</sup>

The new Home was opened on 9 March 1912 and guests were invited to view the house and the beautiful grounds. After formally opening the Home, the Bishop of Birmingham said his experience of the Friedenheim in London had taught him how such a Home 'filled the void which could be filled in no other way'.<sup>88</sup> Such institutions were distinct from other kinds of hospitals or sanatoriums and he predicted that 'such hospitals were going to be the outlet for more and more private and voluntary effort'.<sup>89</sup> Mr Aston, Honorary Secretary, used the occasion to encourage the practice of endowing beds. He reported that Dr Annie Clark had presented the home with £750 on her retirement; this was sufficient to endow a bed for 20 years. Similarly, Miss Wilson had collected a few friends together and raised enough to endow a bed for 10 years; this was more useful than special donations although the Secretary acknowledged these often resolved an end of year crisis.<sup>90</sup> The

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<sup>86</sup> C. Saunders, 'Hospice', *Mortality*, 1:3, (1996), pp. 317-22.

<sup>87</sup> BCA, BMHW, TMH, HC/WH 1/13/3, General Committee, 12 January 1912.

<sup>88</sup> Ibid., TMH, HC/WH 1/13/4, Annual Report, 1912. The Friedenheim was founded in 1885 in Mildmay Park by Miss Frances Davidson. Unfortunately little archival material has survived.

<sup>89</sup> Ibid.

<sup>90</sup> Ibid.

original plan had been to take only patients from the Women's Hospital but, with additional beds, it was suggested that general practitioners should be told that the Home would accept direct referrals for 'patients suffering from hopeless malignant disease' into the private wards.<sup>91</sup> Perhaps to encourage this it was also decided that the Home should have an open day, to give medical colleagues and the public an opportunity to look around the Home and learn about its work.

As with other institutions for the dying poor, the purpose of the Home was to nurse women during the very last stages of their illness although at the Taylor Memorial Home there was a difference in the emphasis of care. Four of the Homes mentioned above were established by religious orders or had strong denominational allegiances. The Hostel of God, Clapham (1891), was run by Anglican sisterhoods, as was the Home of the Compassion of Jesus, Deptford (1903). Similarly, St Luke's House in Regent's Park (1893) was closely aligned to the Methodist West London Mission, whilst St Joseph's Hospice, Hackney (1905), was run by a Catholic order, the Irish Sisters of Charity. Most patients in the above Homes were admitted from local religious-based sources, such as religious sisterhoods or clergymen, whilst the nursing care was usually supplied primarily by the Sisters, with a few lay nurses to help.<sup>92</sup> Although the alleviation of the patient's bodily suffering was regarded as important in these Homes, the over-riding aim was saving the patient's souls. For example, Howard Barrett was clear about the role of St Luke's House and wrote 'The body we cannot cure but the Holy Spirit may

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<sup>91</sup> Ibid., HC/WH 1/13/3, General Committee, 14 June 1912.

<sup>92</sup> Humphreys, 'Waiting for the Last Summons', pp. 149, 156.

use us as instruments in the cure of the soul.'<sup>93</sup> Thus, Clare Humphreys has suggested that these Homes were 'first and foremost religious institutions (and) the management of the deathbed in homes for the dying was determined primarily by spiritual objectives and the overriding aim of saving patient's souls'.<sup>94</sup>

As was the practice at the Women's Hospital, the primary focus at the Taylor Memorial Home was the physical care of patients, with the emphasis on making them as comfortable and pain free as possible. This approach reflected the changing attitudes towards death in the late Victorian and early Edwardian years. By the late nineteenth century the Victorian view of death, as something that was ordained by the will of God, was giving place to an understanding that death was more often the result of disease. Thus the primary concern was the freedom from pain and suffering.<sup>95</sup> However, this policy was also in tune with that adopted in the other Institutions of the Charity. As noted in Chapter Four, despite the deeply held religious convictions of the Governors, and many of the medical staff, there was no attempt to impose their views on the patients under their care. Nevertheless, ministers of all religions were welcome at the hospitals and provision had been made, usually at the request of patients and staff, for a 'quiet room' for prayer. Over time, these had evolved into more formal chapels, largely as a result of gifts, special donations or fundraising. For example, Christine Feeney donated stained-glass windows for the chapel at the Women's

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<sup>93</sup> 'The Report of St Luke's House', 6th West London Mission Annual Report 1893. Cited *ibid.*

<sup>94</sup> *Ibid.*, p. 157.

<sup>95</sup> P. Jalland, 'Victorian Death and Its Decline: 1850-1918', in P.C. Jupp and C. Gittings (eds), *Death in England. An Illustrated History* (Manchester, 1999), p. 242.

Hospital and the matron and staff organized sales of work towards the decoration of the chapel at the Taylor Memorial Home.<sup>96</sup>

As Pat Jalland has noted, before the advent of sulphonamide drugs in the 1930s medical science had limited power to cure disease and the treatment of disease was mainly palliative. Yet Victorian doctors had a remarkably good record of terminal care and nineteenth-century physicians such as William Monk, have been seen as forerunners of the modern hospice movement.<sup>97</sup> Monk emphasized the importance of relieving pain and discomfort in the care of a dying patient. The use of opiates in the control of pain was vital and the correct dosage was that which provided relief. Addiction was not considered a problem when a disease was terminal. Monk also offered practical advice on relieving distressing symptoms such as restlessness and difficulty in breathing and the administration of appropriate food and alcohol.<sup>98</sup> The same principles underpinned the care of the patients admitted to the Taylor Memorial Home. Around 44 patients were admitted each year, usually in the terminal stages of cancer. Many were young women, such as Rose, aged 33 years and the mother of five children, who was diagnosed with advanced carcinoma of the cervix. Rose clearly waited too long before seeking help; she had the symptoms of advanced disease on admission and was thought to be near her death. Palliative care, in the form of Benger's food for nutrition and morphine to relieve pain, was given and staff endeavoured to ensure her last days were as dignified and free from pain as possible.<sup>99</sup> The average length of stay was three to four months but like Rose, most patients died at

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<sup>96</sup> TMH, HC/WH 1/13/3, General Committee, 13 March 1917.

<sup>97</sup> Jalland, *Victorian Death*., pp.240-41.

<sup>98</sup> *Ibid.*, pp. 241-42.

<sup>99</sup> BCA, BMWH, HC/WH 3/3/2, Case notes of Mr John Hewetson, 1911.



the Institution, although some improved to such an extent that they were able to return to their own homes for a time.

The outbreak of the war in 1914 did not significantly alter the pace of life at the Home although the departure of the Matron, Miss Richmond was a major blow. The founding of the Home was greatly due to her initiative and she remained a constant source of support.<sup>100</sup> Richmond was also closely involved in the decision on which patients to transfer to the Home and it is perhaps no coincidence that the question of unsuitable cases being sent to the home was raised shortly after she left. The Secretary was asked to write to the Women's Hospital concerning patients who had been transferred in a dying condition, who very often passed away within a day or two of arriving, as this was upsetting to other patients in the Home.<sup>101</sup> Of greater concern, was the acute shortage of staff; before the war the Women's Hospital had supplied nurses for the Home but in June 1917 they informed them that they could no longer do so as they were finding it difficult to manage themselves. Acknowledging that 'the work at the Home being at times especially arduous and exacting', the House Committee agreed that the Matron should advertise for her own nurses.<sup>102</sup>

The financial position was more encouraging; the Secretary reported that had received £400 at 4.5 per cent on account, from Dr Bernay of Solihull with the purpose of endowing a bed in memory of his wife. In the same month a subscriber, who wished to remain anonymous, offered to pay off the deficit of the years working.<sup>103</sup> The following year, Dr Mary Sturge reported that 'her

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<sup>100</sup> Ibid., HC/WH 1/10/6, Annual Report, 1915.

<sup>101</sup> Ibid., TMH, HC/WH 1/13/3, General Committee, 10 November 1916.

<sup>102</sup> Ibid., HC/WH 1/13/3, General Committee, 29 June 1917.

<sup>103</sup> Ibid., 14 April 1916.

two brothers had donated £52 a year for 10 years, in thanksgiving for the good health and long life of their mother, now aged 86 years'.<sup>104</sup> Nonetheless, they were under constant financial pressure and by November 1917, the Secretary reported that they were £412 overdrawn.<sup>105</sup> It was a great relief, therefore, when the following year the Women's Hospital offered to give them a proportion of the money it had received in response to their own appeal for money to pay off bank overdrafts. A sum of £900 was transferred to the Taylor Memorial Home's account which had paid off the whole debt, leaving a surplus of £50 to help with the expenses of the current year. In the same month it was noted that the sum of £500 had been donated by a Mrs Ingles of Moseley, which was invested in a war loan.<sup>106</sup> By the spring of 1919, things were getting back to normal. Bates, the gardener was being demobilized and returning to his work, news that was particularly welcomed by the patients. The grounds of the Home which had given so much pleasure had been turned into allotments during the war and the access allowed had resulted in a good deal of damage to the flower beds and shrubs. Whilst this was a minor inconvenience at a time of national emergency it was upsetting to patients and staff alike. The garden was regarded by all as a place of peace and tranquillity and used by patients and their visitors for much of the year. Friends and supporters rallied round, the garden was replanted and the greenhouse repaired.

As noted in the previous chapter, it was not easy to find new subscriptions during the inter-war years and the Chairman was obliged to write to the subscribers, asking for an increase in their subscriptions. Advertisements

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<sup>104</sup> Ibid., HC/WH 1/13/4, Annual Report, June 1917.

were also regularly placed in local newspapers, describing the work of the Home. These seldom had the required response although a personal letter to subscribers from Sir Arthur in 1923 was more fruitful; it was reported at the Annual Meeting that this had resulted in an increase in new subscriptions and donations.<sup>107</sup> Notwithstanding the financial pressure, Mary Sturge was very anxious to establish a pension fund for those members of staff who dedicated themselves to the service of the Home. It is possible that her work with the Suffrage Society in Birmingham (discussed in Chapter Two) had heightened her awareness of the difficulties that single professional women faced in later years. It could not be pretended, she said, that 'the salaries paid would enable the people who work there to save properly for their old age and if anyone ought to be helped in providing for their retirement, it was the noble women who worked in that Institution'.<sup>108</sup> In April of that year she reported that £100 had already been collected to provide a pension for the senior sister when she retired and a further £90 had been collected to start a benevolent fund to provide a pension for other members of staff.<sup>109</sup> Sturge also presented a pamphlet setting forth the need for proper accommodation for the nursing staff, an issue that had long concerned her.<sup>110</sup> Sadly, Sturge was unable to see her scheme come to fruition; after a short period of illness, she died on 14 March, 1925.

A member of one of Birmingham's leading families, Mary Sturge was well known in the city both as a physician and a social reformer. After obtaining

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<sup>105</sup> Ibid., HC/WH 1/13/3, General Committee, 23 November 1917.

<sup>106</sup> Ibid., 13 June 1918.

<sup>107</sup> Ibid., HC/WH 1/13/5, Annual Report, June 1923.

<sup>108</sup> Ibid.

<sup>109</sup> Ibid., and HC/WH 1/13/3, General Committee, 14 December 1923.

<sup>110</sup> *Birmingham Post*, 1 April 1925.

her MD from London University in 1891 Sturge gained experience at the Royal Free Hospital and at the New Hospital for Women, where she was senior resident house surgeon.<sup>111</sup> Sturge spent some time in Europe before returning to Birmingham in 1896, being only the second lady doctor to undertake medical work in the city and remained in general practice up to the summer before her death.<sup>112</sup> In reviewing her medical career, the *Daily Gazette* paid tribute to her role as a physician to the Women's Hospital, noting particularly her role in starting the Taylor Memorial Home.<sup>113</sup> Fellow doctors and social workers paid tribute to her efforts to advance the cause of temperance and the part she played in writing *Alcohol and the Human Body* in collaboration with Sir Victor Horsley. This work, which was undertaken to put pressure on the Board of Education to teach hygiene and temperance in schools, became the standard text on the effects of alcohol. Others spoke of her self-sacrificing life and work with the 'suffering poor'; speaking on behalf of the medical women of Birmingham Dr Rose Molloy said that she had 'never met anyone so absolutely selfless as Dr Mary Sturge'.<sup>114</sup> Less well known was her work with refugees during the war years for which she was presented with the 'Medaille de la Reine Elisabeth' from the Belgian government.<sup>115</sup>

As was widely acknowledged in her obituaries, Mary Sturge had always been deeply committed to the Taylor Memorial Home and it was her dying wish that her brothers and sisters should do all they could to support it. After discussions with Christopher Martin and the Secretary, they decided to start a

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<sup>111</sup> *Birmingham Mail*, 14 March 1925.

<sup>112</sup> Louisa Atkins, discussed in Chapter Two, being the first women doctor to practice in Birmingham.

<sup>113</sup> *Daily Gazette*, 14 March 1925.

<sup>114</sup> *Ibid.*, 20 March 1925.

<sup>115</sup> *Ibid.*, 14 March 1925.



fund in her memory to provide the improved accommodation for the nursing staff and additional single rooms for patients, in line with the proposals Sturge made shortly before her death.<sup>116</sup> By April 1925, £3,700 had been collected and donations continued to be received over the following months.<sup>117</sup> At the Annual Meeting in 1926 a cheque for £210 was presented by the Federation of Medical Women (later the Medical Women's Federation) to be used to convert two rooms into private wards for 'poor gentle-people' who could not afford to be nursed in a private nursing home. Miss Ivens (President of the Federation), said 'the gift was meant to testify to the great esteem and love to which Dr Sturge, who was the first provincial president of the Federation, was regarded by members'.<sup>118</sup> The Dr Mary Sturge Memorial Wing, which opened on 1 April 1926, greatly added to the amenities of the Home a point the local press, who were always very supportive of the Institution, emphasized. The *Birmingham Mail*, the *Birmingham Post* and the *Express* all carried photographs of the extension and articles describing the work of the Home. It was, according to the *Birmingham Post* 'a quiet haven where life may be laid down more easily and with every alleviation of pain'.<sup>119</sup>

As noted above, before in the 1930s, the power of therapeutic medicine to cure disease was somewhat limited but much could be done to minimize physical suffering by reducing 'the pain, discomfort, and fear associated with dying'.<sup>120</sup> This was the aim of the Taylor Memorial Home; at the Annual Meeting in 1932 Christopher Martin said 'They did not pretend to be able to

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<sup>116</sup> BCA., BMHW, TMH, HC/WH 1/13/3, General Committee, 12 March 1924, *Birmingham Post*, 1 April 1925.

<sup>117</sup> Ibid.

<sup>118</sup> BCA, WHB, TMH, HC/WH 1/13/5, Annual Report, July 1926.

<sup>119</sup> *Birmingham Post*, 20 July 1928.

<sup>120</sup> P. Jalland, *Death in the Victorian Family* (Oxford and New York, 1996), p. 77.

cure the patients there but they did something equally necessary and helpful; they alleviated the pain of the sufferers all they could and comforted them in every possible way.<sup>121</sup> It would appear this philosophy struck a chord with subscribers; many people donated money or gifts in kind specifically for the provision of extra comforts for the patients. One subscriber, for example, donated £1,000 worth of shares and specified that the income was to be used solely for provision of small luxuries, such as flowers, fruits, special articles of diet plus providing the patients with the opportunity for an occasional drive in the fresh air.<sup>122</sup> The Home was further improved by the generous gift of a large glass veranda; this was a tremendous boon to patients, as the beds could be wheeled out onto the veranda during the summer months.<sup>123</sup> Christopher Martin's address to the Annual Meeting in 1932 was to be his last; on 31 January 1933, the Committee of Management at Sparkhill reported his death and paid tribute to the 43 years service he had given to the Women's Hospital and all its Institutions, particularly the Taylor Memorial Home of Rest and Gertrude Myers Convalescent Home, Martin being Chairman of both. Mr Aston spoke of his enthusiasm for his work and noted the considerable financial assistance Martin had given to the hospital, in addition to his medical services.<sup>124</sup> The warmest tribute, however, came from one of his surgical patients who wrote:

It seems to me among those who most realise his loss are his innumerable women patients. ... It is we who could tell how generous he was, how extraordinary skilful he was, how thoughtful for the pain that

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<sup>121</sup> BCA, WHB, TMH, HC/WH 1/13/6, Annual Report, July 1932.

<sup>122</sup> Ibid., HC/WH 1/13/3, General Committee, 5 September 1930.

<sup>123</sup> Ibid., HC/WH 1/13/6, Annual Meeting, July 1932.

<sup>124</sup> Ibid., HC/WH 1/2/11, Management Committee, 31 January 1933.

others were suffering. He was a radiant person, with kindness and his great utter simplicity was that of the great man.<sup>125</sup>

There was a growing demand for such an institution. The incidence of cancer was on the increase. It was reported at the Annual Meeting in 1930 that in England and Wales every year 56,000 people died of cancer; in Birmingham the deaths from that disease in 1929 were between 1,300 and 1,400.<sup>126</sup> Steel-Maitland observed that they had so many applications that there was really a need for larger home. It was noted that 38 patients had been admitted during the year, 19 of whom had died.<sup>127</sup> The medical staff were hopeful that with the use of radium and x-rays the death rate could be reduced but to get the best results from those methods the cases had to be seen early. It was still the case that patients consulted their doctor only when the disease had progressed to the state of being inoperable.<sup>128</sup> As noted above, Homes for the dying had been established in the early decades of the twentieth century but it would appear that there had been little increase in the number of institutions that offered palliative care. Speaking at the Annual Meeting in 1930, the Lord Mayor noted that subscriptions came from as 'far afield as Northampton, Torquay, Dover, Dorset, Essex, Sussex, London, Bath, Surrey, Scotland and Wales'.<sup>129</sup> Nonetheless, as with most voluntary hospitals, the Taylor Memorial Home struggled financially. Every bed cost £130 a year to maintain, yet the subscription list amounted to only £400 a year. This resulted in an annual deficit which in 1939 amounted to over £500. The Mayor was perhaps overly optimistic in expressing the thought that now

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<sup>125</sup> Ibid., HC/WH 1/13/3, General Committee, 10 February 1933.

<sup>126</sup> *Birmingham Post*, Report of Annual Meeting, 12 July, 1930

<sup>127</sup> Ibid.

<sup>128</sup> Ibid.

this had been pointed out, the public would do its best to resolve the deficit during the coming twelve months. However, regardless of the outcome of his appeal the Mayor assured those present that all associated with the hospital had, at any rate, the sincere thanks of the citizens of Birmingham.<sup>130</sup>

The relative peace and calm of the inter-war years was rudely shattered during the winter months of 1940-41, when patients had to endure the ordeal of bombing raids over Birmingham, including the fall of a high explosive bomb on the lawn of the Home. The house in Showell Green Lane was shut up and the staff given leave of absence while a search was made for a new house in quieter surroundings. Subsequently, a house was found at White Lodge, Cannock, and the Home re-opened on 2 April 1941.<sup>131</sup> The reporter for the *Birmingham Weekly Post* described White Lodge as a delightful spot, right on the edge of Cannock Chase. The front garden was full of roses and at the back of the house there was a swimming pool, a tennis court and an extensive kitchen garden. The inside of the home was described as 'a haven of coolness and calm', with a 'really lovely view of the countryside which was visible from all the rooms at the back of the house, including the two wards'.<sup>132</sup>

This somewhat idealistic description belied the reality of day-to-day life in the Home. The nursing situation was very acute; there was only Sister Newton and one assistant nurse, a situation which the Management Committee acknowledged was worrying. As Cicely Saunders has noted, aside from clinical competence and nursing skills, palliative medicine requires

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<sup>129</sup> Ibid.

<sup>130</sup> Ibid.

<sup>131</sup> *Birmingham Weekly Post*, 1 August 1941.

<sup>132</sup> Ibid.



friendship and care of emotional problems.<sup>133</sup> Without sufficient staff it was impossible to take the type of patients the Institution had been founded for. Thereby, only patients who were convalescing from radium treatment, who did not need night nursing, were admitted. Whilst these had benefited from the good nursing, rest and change, with limited staff only a few women could be admitted.<sup>134</sup> The following year the staff were further depleted when, due to family reasons, Sister Newton had to leave. The Matron reported that she was trying to get more help but, despite her efforts, six months later she had to tell the Governors that the number of staff was still not adequate to nurse dying patients.<sup>135</sup> An additional concern was that the future of the Home was uncertain; the intention had been that the Home be moved for the duration of the war but at the Annual Meeting in 1946, it was reported that the Women's Hospital had taken over Showell Green House. Notwithstanding her disappointment, Mrs Barrow Cadbury pointed out that the Women's Hospital owned the property, and that they should remember that it had not been their home for a number of years. All was not lost however; they had succeeded in purchasing an empty property, known as The Grange in Erdington, for the sum of £2,000. The building had been used by the WRAF for four years and required a considerable amount of refurbishment. It was estimated that it would take a further £10,000 to convert the building to their purpose.<sup>136</sup>

The Annual Meeting in 1948 was to be the last under the current management. In her final address the President, Mrs William Cadbury, who had been connected with the Home from its founding in 1910, said:

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<sup>133</sup> Saunders, 'Hospice', pp. 317-22.

<sup>134</sup> BCA, WHB, TMH, HC/WH 1/13/3, General Committee, 7 October 1946.

<sup>135</sup> Ibid., 28 March 1947, 14 September 1947.

<sup>136</sup> Ibid., HC/WH 1/13/7, Annual Report, 1946.

I do not wish the meeting to be a sad or funeral affair but rather one of rejoicing that so much beneficent work has been accomplished. We are all familiar with the establishment of the Home and we remember with gratitude the help given by Dr Sturge, Mr Martin and many others in the past, and we know that the spirit with which they worked will carry on with the new authorities.<sup>137</sup>

Mrs Cadbury acknowledged with gratitude the services rendered by the Matron, Miss Crowther and stated that an annuity had been purchased to the extent of the outstanding credit of the Pension Fund which would commence on the date of the Matron's retirement. She also thanked the Honourable Secretary, Mrs Aston, who had faced many difficulties since the Home moved to Cannock and had expended so much energy in finding a suitable residence in Birmingham, for the wonderful service she had given to the Home. After expressing her appreciation for the presentations and kind words spoken about her, Mrs Aston was able to report that, with the help of the architect they had succeeded in turning the Grange from a ruin into the extremely nice building. She was also hoping to gain permission for a veranda to be built along the south side of the home, in a similar fashion to the one that had been erected at their previous home. One of the current committee members, Mr Grosvenor, was to be chairman of the new committee, so the link with former colleagues would not be lost. Grosvenor stated that he looked forward to his association with the new scheme and he wanted the meeting to close 'with the feeling of confidence in the knowledge that the new Health Act was not

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<sup>137</sup> Ibid., Annual Meeting, June 1948.

only desirable but capable of administering a great service to the sick'.<sup>138</sup> The words of Mrs Aston surely reflected the thoughts of those present; she 'hoped the Taylor Memorial Home would rise again'.<sup>139</sup>

The aim of this chapter has been to look at convalescent care and the care of the terminally ill, within the context of the unemployment and social suffering in Birmingham during the inter-war years. As has been shown, in some parts of the city, there was a significant degree of deprivation and poor health, sometimes related to the social circumstances of women. The Governors and medical staff sought to mitigate this by introducing new support roles such as social workers and after-care workers. They also extended their remit of care, by establishing Convalescent Homes and the Taylor Memorial Home of Rest. This suggests that those who founded and supported voluntary hospitals had a more holistic approach to patient care than has sometimes been acknowledged. It also demonstrates the importance of personal involvement and local management of health care facilities. The regular contact between Governors, medical and nursing staff, and their interaction with the women under their care, gave them a real understanding of the needs of their patients. Thus, the services they provided were tailored to meet their needs. Whilst each Institution was separately financed and managed by its own Committee, the parent Institution remained in overall control. This position was formalized in 1933 when it was agreed to amend the constitution to incorporate all the hospitals (including the Maternity Hospital, discussed in the following chapter) and rename the Charity, The

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<sup>138</sup> Ibid.

<sup>139</sup> Ibid.

Birmingham and Midland Hospitals for Women (Incorporated).<sup>140</sup> It is to this speciality, the care of mother and child that we turn our attention in the next chapter.

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<sup>140</sup> Ibid., HC/WH 1/2/11, Management Committee, 21 January 1933.



## **Chapter 7**

### ***Mother and Child***

#### ***The Maternity Hospital and Lying in Charity c.1911-1948***

The closure of the original Lying-in Hospital in 1867, and the move towards a domiciliary service was discussed in Chapter One. Notwithstanding the success of this service in relation to normal deliveries, it was subsequently found that a small maternity hospital was needed for serious cases. Therefore, a decision was made to open the Loveday Street Lying-in Hospital. However, the district service was maintained and the majority of mothers continued to give birth at home. The aim of this chapter is to examine how the maternity services developed at a time when there was a national interest in the provision of maternity care. The early decades of the twentieth century were an important time in the history of childbirth, as measures were introduced to move the responsibility for child health and welfare away from the nineteenth-century model of individual responsibility and local provision towards a more centralized model of care. Among the themes discussed are puerperal fever and the efforts made by the Women's Hospital, Birmingham City Council and other local authorities to tackle this disease. We will also examine the role of the Maternity Hospital in the training of medical staff and midwives, and developments in maternity care. We learnt in the previous chapter of the social circumstances of the working classes in Birmingham. In this chapter we will consider how these conditions affected maternal health and infant welfare. We begin by considering the ideas and beliefs that

underpinned the greater involvement of the state in these matters in the early decades of the twentieth century.

The competing interpretations of social policy in the early decades of the twentieth century were discussed in the introduction to this thesis. Particularly influential has been the feminist analysis which links the increasing interest the state took in every aspect of maternal behaviour to an imperialistic concern for national efficiency, organized within a patriarchal perception of a woman's social function.<sup>1</sup> Another enduring interpretation is that the real moving force for change in the treatment of children was the Boer War (1892-1902), when 35 per cent of volunteers were found to be unfit for service.<sup>2</sup> Subsequently, the government commissioned the Committee the Inter-Departmental Committee on the Physical Deterioration of the Population (hereafter, the Committee), to 'inquire into the causes and present extent of the physical *unfitness* that undoubtedly exists to a large degree among certain classes of the population'.<sup>3</sup> In their final *Report* the Committee made 53 recommendations, many of which were concerned with measures to improve the health and welfare of working-class children. Of particular interest in the context of this thesis is the emphasis on infant welfare, for whilst there had been a decline in the general mortality rate, infant mortality failed to follow this trend. Furthermore, the birth rate was steadily declining; between 1876 and 1897 the crude birth rate fell 14.1 per cent.<sup>4</sup> Thereby, as Arthur Newholme

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<sup>1</sup> A.Oakley, *The Captured Womb. A History of the Medical Care of Pregnant Women* (Oxford and New York, 1984), p.34ff, J. Lewis, *The Politics of Motherhood. Child and Maternal Welfare in England, 1900-1939* (Montreal, 1980), p.68.

<sup>2</sup> K Jones, *The Making of Social Policy in Britain 1830-1990* (London, 1994), p.77.

<sup>3</sup> Parliamentary Papers 'Report of the Inter-Departmental Committee on Physical Deterioration' (1904), vol. 1, p.2, para. 7. Cd 2175.

<sup>4</sup> D. Dwork, *War is Good for Babies and Other Young Children. A History of the Infant and Child Welfare Movement in England 1898-1918* (London, 1987), p.4.

observed, 'the lowered birth-rate in this country makes the saving of infantile life a matter of Imperial importance'.<sup>5</sup> Among the causes that contributed to infant death was increased mortality in the neonatal period, due to premature births and congenital defects. In the early months of life, there was a rise in the incidence of pneumonia although this was consistent with the rise in the number of deaths from this disease among the general population. The greatest concern was the number of deaths that were preventable, particularly from diarrhoeal disease and digestive disorders; liver disease was also a common cause of infant death.<sup>6</sup>

We shall return to the subject of infant welfare below but in the late nineteenth century high maternal mortality was also a cause for concern. As noted in Chapter One, there had been earlier concerns regarding the incidence of puerperal fever in lying-in hospitals. Nonetheless, by the late 1880s Professor Playfair considered that confinement in the majority of well-managed lying-in hospitals was as 'safe, if not safer (than) in a large and luxurious private house, with nurse, physician, and all that money can now procure'.<sup>7</sup> The basis for such a claim was a substantial fall in maternal mortality between the late 1870s to the late 1890s. Between the years 1875-79 the Maternal Mortality Rate (MMR) at Queen Charlotte's Hospital had been 268.0 per 10,000 deliveries; by 1895-99 this had fallen to 42.0. Similarly, at the General Lying-in Hospital, the MMR had fallen from 117.0 in the years

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<sup>5</sup> A. Newholme, 'Infantile Mortality', *The Practitioner*, October 1905, p.494. Cited *ibid*, p.23.

<sup>6</sup> 'Report of the Inter-Departmental Committee', Vol.1. Part III, Summary of Recommendations, pp. 85-87.

<sup>7</sup> W.S. Playfair, 'Introduction to a Discussion on the Prevention of Puerperal Fever', *British Medical Journal* (hereafter *BMJ*), 2 (1887), pp. 1034-36. Cited I. Loudon, *Death in Childbirth. An International Study of Maternal Care and Maternal Mortality 1800-1950* (Oxford, 1992), p. 204.

1861-79, to 42.0 by 1895-99.<sup>8</sup> Irvine Loudon has argued that this 'remarkable reduction in maternal mortality' was due to the use of antiseptics.<sup>9</sup> It was against this background that the decision was made to re-open the Lying-in Hospital. From the outset the hospital struggled financially; they had no invested funds and after three years, the financial responsibility was considered to be too great for the Management Committee and their bankers. Nonetheless, they felt the closure of the hospital, which had proved to be needed in obstetric emergencies, would be a great loss. The Committee decided to approach the Women's Hospital to discuss an amalgamation of the two Institutions. They received a sympathetic hearing from the Chairman, Mr Nettlefold, who adjourned the matter until the next meeting of the Sparkhill Management Board, meanwhile asking the Matron, the Medical Board and the Honorary Treasurer to compile a report.<sup>10</sup> Subsequently, the Matron and the Medical Board confirmed that there would be no difficulty from their point of view, indeed they saw many advantages. The maternity work naturally fitted in with the gynaecological work at Sparkhill and, in their view, 'if the preventative part of women's health was well done, they might hope for some diminution in the demand for the curative work in the years to come'.<sup>11</sup>

The major difficulty was cost. It would take an extra £1,500 to £2,000 a year to take on the work of the Maternity Hospital but the Committee had the assurance of their Honorary Treasurer that this could be done. Nettlefold shared the Treasurer's faith in Birmingham's generosity; when they founded

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<sup>8</sup> Ibid., Table 12.5, p.201. Maternal Mortality Rates are expressed as maternal deaths per 10,000 births.

<sup>9</sup> Ibid., p.204.

<sup>10</sup> Birmingham City Archives (hereafter, BCA), Archives of The Birmingham and Midland Hospital for Women (hereafter, BMHW), HC/WH 1/2/5, Management Committee, 13 December 1910.



the Women's Hospital 40 years earlier they had an annual subscription list of £230 and he recalled that 'some prophesized that the Charity would soon be wound up and the work left to those who, in their opinion were better able to deal with it'.<sup>12</sup> Those who were responsible for starting the hospital thought differently; they did not try to do things too quickly but they insisted that 'what was done was done as well as possible ... quality first, quality second has always been one of the abiding principles of the Birmingham and Midland Hospital for Women', and he hoped that it always would be.<sup>13</sup> They had found that the people of Birmingham were willing to pay for good work, well done and, as long as they maintained their work to its present high standard, Nettlefold was confident that the women of Birmingham would not:

... leave their poor sisters to undergo unnecessary and avoidable suffering merely for the want of this little money. It is often said, and I agree, that the hand that rocks the cradle rules the world; surely the hand of the rules the world can raise the little matter of an extra £2,000 a year.<sup>14</sup>

Both parties having accepted the formal proposal to amalgamate, it was agreed that the two hospitals would be kept as separate institutions, jointly governed by the Management Committee of the Women's Hospital, with the addition of six members of the Lying-in Charity. This Committee set the general policy of the two Institutions, while the general management of the Lying-in Hospital was delegated to the Maternity Committee. The objects of the Institutions were:

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<sup>11</sup> Ibid., 12 September 1911.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

### The Women's Hospital:

Reception and treatment of women suffering from diseases peculiar to their sex.

### The Lying-in Charity:

To supply obstetric medical attention and nursing to women in the city of Birmingham, in their own homes.

To provide and maintain a maternity hospital for the treatment of exceptional cases.

To train midwives and midwifery nurses.<sup>15</sup>

At the first joint meeting of the subscribers of the two hospitals Alice Beale, one of the original members of the Maternity Committee, said that it was 'with the deepest regret they had turned their nursling out, three years of age, very poorly equipped financially but it was rather a case of Hobson's choice'.<sup>16</sup> Nevertheless, she thought it was right to ask the Women's Hospital to take over their work. 'It would remove a great deal of mystification in the eyes of the public (and) she believed the old Institution would just take the younger one under its wing and carry it along with the rest of its work.'<sup>17</sup> Beale then gave them details about the work of the Institution; there had been an increase in the number of in-patients which, she was pleased to note, included a due proportion of abnormal cases, because that was what the hospital had been built for. Beale accepted that they had to take a few normal cases, for the education of midwives, 'but those were not the cases for which the hospital was founded'.<sup>18</sup> Conversely, there had been a decrease in the

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<sup>15</sup> Ibid., HC/WH 1/10/5, Annual Report, 1911.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

number of outdoor cases, which Mrs Barrow Cadbury attributed to the 'circumstances of trade in Birmingham being good', which meant that people had been able to afford to pay for midwives themselves.<sup>19</sup> Closing the meeting, the Chairman said he was 'glad to see the scheme for the amalgamation of the Women's Hospital and Birmingham Lying-in Charity had been satisfactorily concluded'.<sup>20</sup> As Nettlefold pointed out, both parties had gained by the merger, the Women's Hospital had extended its work into maternity and the Maternity Hospital had been relieved from a position of financial difficulty.

The latter point was particularly important as the building of a new wing for the hospital was under consideration; this would include a new out-patient department and a waiting room for 60 patients. In addition, there were plans to build a hostel with accommodation for 35 pupil midwives, plus bedrooms for a further five members of staff and five maids.<sup>21</sup> The new building was, however, a long-term project as it involved purchasing the leasehold of adjoining properties which were not available at that time.<sup>22</sup> Meanwhile, the work of the hospital was not greatly affected by the merger; the detailed management of the Lying-in Hospital being delegated to a House Committee of eight, most of whom were members of the old Maternity Committee. As previously, much of the organization of the work of the Lying-in Charity was undertaken by the Investigation Committee. This involved a huge amount of labour; the ladies were required to sift through all the case notes of expectant mothers and arrange treatment, either at the hospital or in the home of the

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<sup>19</sup> Ibid.

<sup>20</sup> Ibid.

<sup>21</sup> Ibid., HC/MH 1/4/3, Maternity Hospital House Committee, 2 March 1926.

<sup>22</sup> Ibid., HC/MH 1/4/2, Maternity Hospital House Committee, 26 September 1921.

patients. There is no indication in the records as to the basis of their decision making but at the Jessop Hospital in Sheffield it was usually women in later pregnancies who were delivered in hospital. At the Jessop, from June until December 1886, only 2 first-time mothers gave birth in hospital compared to 67 women in later pregnancies, 23 of whom had had over five previous pregnancies.<sup>23</sup> Helen Mathers and Tania McIntosh have suggested that women preferred to deliver in hospital because it gave them 'a chance to rest from caring for their families'.<sup>24</sup> It is unlikely the same criteria were used in Birmingham; the records show that the majority of women, around 80 per cent, gave birth at home. The first Maternity Report of the combined Institutions in June 1911 showed that there had been 36 admissions to the hospital, 26 births and one stillbirth. There is evidence to suggest that mothers were admitted if complications of labour were anticipated. Among this number, there had been 2 maternal deaths, 4 infant deaths and 39 mothers had been sent for a further period of rest to convalescent homes. District cases attended numbered 111 deliveries, of which only four had required the assistance of a medical officer. There were no maternal or infant deaths.<sup>25</sup>

A midwifery-led maternity service had long been a feature of the Charity. Between 1863 and 1867, the average number of patients in the original Lying-in Hospital had been 5.5, representing a bed occupancy of a little over 40 per

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<sup>23</sup> H. Mathers and T. McIntosh, *Born in Sheffield. A History of the Women's Health Service 1864-2000* (Barnsley, 2000), p.33.

<sup>24</sup> *Ibid.*

<sup>25</sup> BCA, BMHW, HC/WH 1/2/5, Management Committee, 12 September 1911.



cent.<sup>26</sup> Indeed, although the controversy surrounding puerperal fever in part influenced their decision to close the hospital, in truth the move was taken more on economic grounds.<sup>27</sup> The low bed occupancy made the hospital uneconomical to run and, in the year before its closure, the hospital had a debt of £1,200.<sup>28</sup> As noted above, since the closure of the hospital the domiciliary system had worked well; in the years 1876-80 their MMR, at 14.5 in 4,806 deliveries was amongst the lowest in the country.<sup>29</sup> Nevertheless, an out-patient Lying-in Charity did not appear to have the same appeal to subscribers as a Lying-in Hospital; more importantly it lacked the advantage of a maternity hospital to train midwives and medical staff. Midwifery training was high on the political agenda in the first decade of the twentieth century. The Midwives Act (1902) had highlighted widely differing standards of training. Of the 22,308 names registered on the Midwives Roll in 1905, 7,465 held the Obstetrical Societies Certificate, a further 2,322 held hospital certificates and 12,521 held no certificate at all.<sup>30</sup> These women described as being in 'bona fide' practice, had no formal training and had often learnt their skills by assisting a more experienced midwife. A number of historians have pointed to the advantages of these 'handy-women', noting that although they were often rough and ready, they were of the same class as their clients and therefore less likely to be critical of home conditions; they would also often

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<sup>26</sup> *Birmingham Daily Gazette*, 13 June 1867. I have discussed this further in J.Lockhart, 'Truly, a Hospital for Women': The Birmingham and Midland Hospital for Women 1871-1901, MA dissertation, University of Warwick, 2002.

<sup>27</sup> See *Lancet*, 8 April 1867 for further details of the campaign to close lying-in hospitals.

<sup>28</sup> *Birmingham Post*, 12 December 1866.

<sup>29</sup> Loudon, *Death in Childbirth*, p.199, table 12.3. The average MMR in English out-patient lying-in charities before 1880 was 48.3 per cent. Only Liverpool Ladies Institution's rate was lower, at 13.0 in 6,101 deliveries.

<sup>30</sup> J. Donnison, *Midwives and Medical Men. A History of Inter-Professional Rivalries and Women's Rights* (London, 1977), p.181.

help around the house. A further important consideration was likely to be that they were much cheaper than paying for a doctor to attend the birth.<sup>31</sup>

As Jean Donnison has pointed out, many of these women were totally illiterate and often had difficulty reading a clinical thermometer; few knew how to take antiseptic precautions.<sup>32</sup> It was this large group of untrained women who were most affected by the new legislation. The Act (which became operative in 1903), created a new Central Midwives Board (CMB) as the examining and supervising body of the profession. The Act also prohibited practice by uncertified midwives and stipulated that in future all new midwives must take the examination of the CMB.<sup>33</sup> Prior to this, some hospitals, such as the Jessop Hospital in Sheffield, had instituted their own training programme. Dr Aveling, the founder of the Sheffield Hospital for Women, followed Lawson Tait in being a strong supporter of midwives, believing that they were particularly useful to working-class women who could not afford medical fees. Nevertheless, like Tait he firmly believed that there was an urgent need for midwives to be trained, to prevent that class of midwife who was 'pretentious and ignorant (and) causing misery to many poor sufferers'.<sup>34</sup> The Jessop scheme (started in 1879) incorporated a three-month period of practical training, which included the management of childbirth under supervision and the principles and use of antiseptics in the lying-in room.<sup>35</sup> Similarly, midwifery training started at the Brownlow Hill Lying-in Hospital, Liverpool in the late 1870s. Initially, pupil midwives received three months

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<sup>31</sup> Loudon, *Death in Childbirth*, p.218. Mathers and McIntosh, *Born in Sheffield*, p.49. Lewis, *Politics of Motherhood*, p.20.

<sup>32</sup> Donnison, *Midwives and Medical Men*, pp.181-82.

<sup>33</sup> Loudon, *Death in Childbirth*, p.207.

<sup>34</sup> Mathers and McIntosh, *Born in Sheffield*, p.29. Lawson Tait's views were discussed in Chapter 4.

training for a fee of five guineas. In 1884, this was extended to a period of six months, at a fee of £12. On completion of their training, midwives were entered for the Diploma of the London Obstetrical Society.<sup>36</sup>

As indicated by the statistics above, such training programmes were the exception; in contrast, in the countries of north-west Europe 'a large majority of home deliveries were undertaken by trained and supervised midwives'.<sup>37</sup> These countries had also witnessed a significant fall in puerperal fever and there is evidence to suggest that this can be attributed to the use of antisepsis. As early as 1871, printed instructions were sent to all Danish midwives on the use of antiseptics and the importance of high standards of personal cleanliness. By 1895-89, the MMR in Danish provincial towns had fallen to 18.3, compared to 62.2 in 1870-74.<sup>38</sup> Similarly, Loudon has shown that there was a steep fall in puerperal fever in Sweden where midwives were required by law to use antisepsis and keep a written record of what was used.<sup>39</sup> The link between puerperal fever and the birth attendant was first identified in the latter decades of the eighteenth century in Alexander Gordon's account of 28 cases in which believed he (or midwives), had unwittingly transmitted the disease to some of his patients.<sup>40</sup> The same thesis was put forward in 1850, by James Young Simpson who suggested that 'puerperal fever was transmitted to the patient by the fingers of the birth attendant' and likened the mechanism of contagion in puerperal fever to that

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<sup>35</sup> Ibid., p.30.

<sup>36</sup> M. Roydon, 'Caring for Women and Babies in Liverpool. A History of Liverpool Maternity Hospital and the Women's Hospital', unpublished paper to celebrate 150 years of obstetric and gynaecological services, pp.17-18 (held in Liverpool Public Library).

<sup>37</sup> Loudon, *Death in Childbirth*, p.155.

<sup>38</sup> Ibid., p.157.

<sup>39</sup> Ibid., pp. 158-59.



of surgical fever.<sup>41</sup> In both cases there was a break in the body's natural defence mechanism. In the surgical patient, the wound in the skin made by the knife of the surgeon opens up the underlying tissue; in the puerperal patient, the internal surface of the womb is opened up by the separation of the placenta and the exfoliation of the mucous membrane. In both instances, 'septicaemia could result from the entry of the infection into the blood through the exposed mouth of veins and arteries'.<sup>42</sup> Simpson was quite clear as to the mechanism of contagion:

inflammatory exudate was introduced into the genital tract on the fingers of attendants. Septicaemic puerperal fever resulted from the exudate entering the open mouth of the blood vessels on the raw internal surface of the post-partum womb.<sup>43</sup>

Having identified the cause, the solution was relatively straightforward. The introduction of antisepsis in the operating theatre had significantly reduced the incidence of postoperative infection. What had been achieved in hospitals could and should be achieved elsewhere. Introducing Listerian techniques into the domiciliary system of maternal care was, however, an uphill task. As Loudon has pointed out, puerperal fever was a source of conflict between midwives, general practitioners, and obstetricians.<sup>44</sup> Obstetricians scorned general practitioners' disregard for antisepsis; in return general practitioners accused obstetricians of being patronizing and pointed out that conditions in

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<sup>40</sup> L. Colebrook, 'Puerperal Infection', in J.M. Munro Kerr, R.W. Johnstone and M.H. Phillips (eds), *Historical Review of British Obstetrics and Gynaecology* (Edinburgh and London, 1954), pp.202-03.

<sup>41</sup> I. Loudon, *The Tragedy of Childbed Fever* (Oxford and New York, 2000), pp. 85-86. A similar thesis was put forward by Ignaz Semmelweis in 1847. See *ibid*, pp.203-04.

<sup>42</sup> *Ibid.*, p.86.

<sup>43</sup> *Ibid.*, pp. 86-87.

<sup>44</sup> *Ibid.*, p.163.



general practice were totally different to those in hospital. General practitioners also tended to blame the midwives, accusing them of ignorance.<sup>45</sup> In an attempt to resolve this issue, a resolution was passed at the annual general meeting of the Midwives Institute in 1925, stating 'That there should be a post-mortem examination, by a duly appointed pathologist, on every woman who dies in childbirth, unless otherwise disallowed by a competent official.'<sup>46</sup> The resolution also demanded uniformity in the notification of birth cards, requesting that they should state the name of the person who delivered the woman. It was further demanded that Medical Officers of Health be required to distinguish in cases of puerperal mortality, whether a midwife or doctor was engaged to attend.<sup>47</sup>

The purpose of these three resolutions were: firstly, to establish the pathology of an unexpected or unusual event, as was common in the practice of medicine; secondly, it would identify infringements of the Midwives Act; thirdly, any link between high maternal mortality and the working of the Act should be made clear.<sup>48</sup> It would seem that this resolution was justified; there is evidence to suggest that many general practitioners were resistant to change. The publication of a lecture by Peter Horrocks in 1906, in which he spoke about the importance of antisepsis and urged minimal interference in normal labour, provoked an extraordinary hostile response from those in general practice.<sup>49</sup> A number of doctors justified routine intervention, arguing that modern women were totally different from their forebears; they could not

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<sup>45</sup> Ibid.

<sup>46</sup> 'High Maternal Mortality: Resolutions by the Midwives Institute', *Lancet*, 28 March 1925, p.669.

<sup>47</sup> Ibid.

<sup>48</sup> Ibid.

be expected to give birth without assistance, indeed why should they? One doctor routinely used forceps and chloroform, arguing that it was his mission to save his patients as much pain as possible.<sup>50</sup> Less respectable reasons also emerged, largely around the question of fees and time. A number of practitioners pointed out that to wait for the case to proceed on its own entailed a good deal of waiting which, at the remuneration they received, was really not an option. By comparison, with the use of chloroform and forceps, the whole procedure took between 15 to 40 minutes.<sup>51</sup>

Whilst this practice was perhaps convenient for busy doctors, it did not necessarily lead to a better standard of maternity care. In Manchester, the Medical Officer of Health's Annual Report (1907) revealed that eight cases of forceps delivery by general practitioners were later admitted to hospital with puerperal fever. Six patients 'had extensive laceration of the cervix and vagina, and one had lacerations which extended to the general peritoneal cavity'.<sup>52</sup> In part, the appalling standard of maternity care of some general practitioners can be attributed to the lack of training medical students received in the field of obstetrics. Consultants in the teaching hospitals regarded the subject of little importance and students were advised to 'Get your "midder" out of the way as soon as you can so that you can concentrate on the real subjects'.<sup>53</sup> Nevertheless, it is difficult to generalize about standards in the past and it should be acknowledged that many general practitioners were

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<sup>49</sup> P. Horrocks, 'An Address on the Midwifery of the Present Day', *BMJ*, 1 (1906). Cited Loudon, *Death in Childbirth*, p.164.

<sup>50</sup> *Ibid.*, pp.164-65.

<sup>51</sup> Subsequent correspondence in *BMJ*, 1 (1906). Cited *ibid.*

<sup>52</sup> *Manchester MOH Annual Report 1907*, pp.300-01. Cited J. Mottram, 'State Control in Local Context. Public Health and Midwife Regulation in Manchester, 1900-1914', in H. Marland and A. M. Rafferty (eds), *Midwives, Society and Childbirth. Debates and Controversies in the Modern Period* (London and New York, 1997), p.146, n.78, p.151.

<sup>53</sup> Loudon, *Death in Childbirth*, p.163.

'careful, skilful, and conscientious and not in the least prone to unnecessary intervention'.<sup>54</sup> Notwithstanding the quality of obstetric practice among general practitioners, the MMR was consistently higher among the middle classes than among working-class women.<sup>55</sup> Loudon has argued that this can be attributed to the fact that middle-class women were most often delivered by doctors, usually general practitioners who were more likely to undertake repeated vaginal examinations and use instruments in normal labours. A further important point is that such doctors were much more likely to come into contact with non-maternity patients suffering from streptococcal disease and become carriers of the streptococcus.<sup>56</sup>

In spite of the potential risks of home delivery, the Governors noted at their Annual Meeting in 1914, that puerperal fever had 'been almost stamped out among the richer people'.<sup>57</sup> However, it is unlikely that they had forgotten the tragic consequences of this disease. As noted in Chapter Four, Joseph Chamberlain had twice been widowed whilst still a young man. His first wife, Harriet died two days after giving birth to their second child on 16 October 1863. His biographer, J.L. Garvin does not give the cause of her death but the circumstances suggest it may have been puerperal fever.<sup>58</sup> For some years after her death Chamberlain was inconsolable; the children were taken to their maternal grandparents and Chamberlain put his energies into the

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<sup>54</sup> Ibid., p.221.

<sup>55</sup> I. Loudon, 'Midwives and the Quality of Maternal Care', in Marland and Rafferty (eds), *Midwives Society in Childbirth*, pp.183-84.

<sup>56</sup> Ibid., p.185.

<sup>57</sup> BCA, BMHW, HC/WH 1/10/6, Annual Report, 1913. By 1910 deaths from puerperal fever had fallen to 13 or 14 in England and Wales. Loudon points out that there could have been other explanations for this decline and stresses the links between puerperal fever and other infectious diseases. See *Childbed Fever*, p.153 ff.

<sup>58</sup> J.L. Garvin, *The Life of Joseph Chamberlain, Volume 1, 1836-1885* (London, 1932), pp.77-79.

family business.<sup>59</sup> Five years after her death Joseph married Florence Kenrick, his first wife's cousin; Garvin has indicated that for nearly 7 years he knew real happiness again. Presiding over a meeting at the Town Hall, on 9 February 1875, Chamberlain received a note to say the birth of their expected child was imminent; four days later their child was born. Despite the delay, there seemed no cause for undue anxiety and the following day the doctor left the house at half past four in the afternoon, saying all was well. At five o'clock Florence suddenly fainted and died in a moment, followed a few hours later by the child.<sup>60</sup> Shortly after her death, Chamberlain wrote 'I have had in my wife a friend and councillor, intensely interested in the objects for which I have striven, heartily rejoicing in my success and full of loving sympathy in occasional failure and disappointment.'<sup>61</sup> This naturally had a lasting effect on Neville Chamberlain (the only son of Joseph and his second wife, Florence), and on Neville's wife, Anne who had developed a close bond with Joseph Chamberlain, before his death July 1914.<sup>62</sup> As we have seen in earlier chapters, there were close family and business links between the Chamberlain, Kenrick and Nettlefold families and a number of other Governors had also been deeply affected by the sudden deaths of these two young women; perhaps none more so than Alice Beale. The fourth daughter of Timothy Kenrick, Alice was sister to Florence and cousin to Harriet Chamberlain; their early death in childbirth was perhaps one explanation for

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<sup>59</sup> *Ibid.*

<sup>60</sup> *Ibid.*, pp. 174-75.

<sup>61</sup> *Ibid.*, Chamberlain left these words to be read one day by her children, p.207.

<sup>62</sup> A. J. Crozier, Chamberlain, (Arthur) Neville (1869-1940), Prime Minister, p.1 <http://www.oxforddnb.com/articles/3232347-article.html>, accessed 1 July 2007.



her interest in the Maternity Hospital, which she was largely responsible for establishing.<sup>63</sup>

Thereby, it is probable that both Governors and medical staff were deeply committed to the cause of maternal health and were determined to tackle this disease, but in practice this presented a number of problems. Dora Colebrook's investigation at Queen Charlotte's Hospital in the 1930s revealed that the danger of haemolytic streptococci infection (the causal factor in the disease) arose from many directions; from an infected throat, either by nasal secretion to a midwife's handkerchief and so to her hands; from an infected abrasion on the mother's skin or from a child's impetigo; by droplets spraying directly on to the vulva by coughing or sneezing; or dust particles by airborne transmission.<sup>64</sup> Thus, it was possible that a number of mothers contracted the infection, either from their own extra-genital strain, another member of the household or dissemination through the air.<sup>65</sup> We learnt in the previous chapter of the difficulties women faced in trying to keep their homes clean in the inter-war years, without basic facilities such as running water. It would be unrealistic to expect such women to maintain the higher standards of hygiene more easily achievable in middle-class homes.<sup>66</sup> The Governors were fully aware of the social conditions of the working classes; elected to Birmingham City Council in 1911, Neville Chamberlain was made Chairman of 'a special committee charged with investigating the housing conditions of Birmingham's

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<sup>63</sup> *Birmingham Post*, 21 March 1940.

<sup>64</sup> D. C. Colebrook, *The Source of Infection in Puerperal Fever Due to Haemolytic Streptococci*, Medical Research Council, Special Report. Series, No. 205 (London, H.M.S.O). Cited Colebrook, 'Puerperal Infection', p.208.

<sup>65</sup> *Ibid.*

<sup>66</sup> Lewis makes a similar point, noting that, 'given both poor sanitation and lack of hot water, little more in the way of domestic cleanliness could be expected', *The Politics of Motherhood*, p.65.

poorest citizens'.<sup>67</sup> Thereby, the Governors realized that it was unlikely that they could stamp puerperal fever out altogether, but they were hopeful that it could be 'greatly diminished among the poorer classes'.<sup>68</sup> As treatment to cure puerperal fever was not available at that time, the priority was to prevent the spread of the infection.<sup>69</sup>

Aside from the measures taken in relation to the training of midwives and medical staff (discussed below), isolation of the patient was the most effective and practical step that could be taken to prevent the infection spreading; hence, the importance of Margaret Ward. As noted in Chapter Five, Margaret Ward opened in 1910, with the purpose of admitting septic cases without risk of infection to other patients. Since the ward opened it had been fully occupied; it dealt with all septic cases from the Lying-in Hospital and in 1911, the Management Committee reached an agreement with the Health Committee to deal with cases of puerperal fever on behalf of the city. This extra work entailed enlarging the ward to provide an additional 18 beds, increasing the total to 25, plus a small ward for babies. As additional staff would have to be employed, it was also necessary to provide extra accommodation for nurses; the total cost of this work was estimated to be approximately £4,000.<sup>70</sup> In part, these costs were defrayed by the contribution the City Council made towards the upkeep of 14 beds, which amounted to £1,008 per year. This contribution only covered 3/5 of the

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<sup>67</sup> Crozier, 'Chamberlain', p.5. Chamberlain recommended moving the working classes 'from their hideous and depressing surroundings to cleaner brighter and more wholesome dwellings' outside the city centre. These proposals were implemented in the inter-war years.

<sup>68</sup> BCA, BMHW, HC/WH 1/10/6, Annual Report, 1913.

<sup>69</sup> Effective treatment to control puerperal fever was not available until the arrival of sulphonamides in the 1930s. See Colebrook, 'Puerperal Infection', pp. 217ff, for a comprehensive account of the treatment of puerperal infection.

<sup>70</sup> BCA, BMHW, HC/WH 1/2/5, Management Committee, 31 November, 12 December 1911.

annual cost of the beds; moreover, it did not cover more than half the total increase. Accordingly, the Management Committee launched an appeal and, with sufficient money being received or promised, work commenced and the extension was ready for reception in June the following year.<sup>71</sup> At the Annual Meeting in 1914, Christopher Martin reported that the previous year they had taken 190 cases into Margaret Ward, 170 to 180 of which were puerperal sepsis. As Martin pointed out, this was not only to the advantage of the individual patient but to the whole community; it was a highly infectious disease and, by isolating septic patients, it helped to prevent the spread of puerperal fever among other women.<sup>72</sup>

The work of Margaret Ward continued to increase; in 1917, 416 cases were admitted, of which 331 cases (79 per cent) underwent surgery. The overall mortality rate for the ward was 7.2 per cent but it was noted that, 'many of the cases were admitted in a very poor condition and too ill for surgery'.<sup>73</sup> Notwithstanding the increase in admissions, this does not necessarily equate to a larger number of cases of puerperal fever in the city. As Martin observed, if they had admitted all the cases that were waiting they would need a hospital twice or three times the size.<sup>74</sup> The pressure on beds was partially relieved in 1926, when the Birmingham Health Committee asked the hospital to supply a nurse for puerperal fever cases, where these were not admitted to hospital. This was considered helpful, as the previous month Worcestershire County Council had asked the hospital if they would take puerperal fever cases from North Worcestershire. The Management Committee agreed to offer them a

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<sup>71</sup> Ibid., HC/WH 1/10/6, Annual Report, 1912.

<sup>72</sup> Ibid., Annual Report, 1913.

<sup>73</sup> Ibid., Annual Report, 1917.

<sup>74</sup> Ibid., Annual Report, 1913.

one-year contract for £3 3s per week, which was the approximate cost to the hospital.<sup>75</sup> The need for dedicated accommodation for septic cases did not significantly diminish over the years; in 1929, 159 cases of puerperal fever or septic abortion were admitted to Margaret Ward.<sup>76</sup>

**Table 6**  
**Cases of Infection following Pregnancy (Margaret Ward), 1929.**

Disease	No. of cases	Operations	Died
Puerperal Sepsis	98	2	4
Puerperal Sepsis with Abscess (Colpotomy)	1	1	0
Puerperal Sepsis with Breast Abscess	12	12	0
Septic Abortions	48	27	5
Totals....	159	42	9

Speaking on the subject at the Annual Meeting in 1914, Dr John Robertson (Medical Officer of Health), did not state the total number of cases of puerperal fever in Birmingham but said he was conscious of many cases being left in the past under the most filthy conditions, and that some women in the city did not get proper treatment. He acknowledged that conditions had since improved, due largely to the training of midwives and medical students at the Women's Hospital and the Maternity Hospital. Robertson said there was no doubting the standard of midwifery in the town had got much better but on the other hand he hoped it would go on improving. The surest way of preventing the spread of the disease was by having more skilled and better trained doctors and midwives.<sup>77</sup> This sentiment was echoed by Frederick Edge, who said that lay Governors and medical staff alike wanted 'such a

<sup>75</sup> Ibid., HC/WH 1/3/10, House Committee, 19 October 1926, 21 September 1926.  
<sup>76</sup> Ibid., HC/WH 1/10/8, Annual Report, 1929  
<sup>77</sup> Ibid. HC/WH 1/10/7, Annual Report, 1914.



standard for Birmingham midwives (that) people would say she comes from Birmingham, she is all right'. Mary Sturge took a slightly more pragmatic view, pointing out that 'if they were going to have the Birmingham brand of midwives they must have Birmingham money'.<sup>78</sup>

Herein lay the problem; the finances of the Maternity Hospital were a constant cause for concern. The Governors did not think they could close the hospital through want of funds; neither did they think the public of Birmingham and district would wish them to do so. The alternative was a municipal hospital, as advocated by the Women's Co-operative Guild, but the Governors thought this would be a very expensive option for the ratepayers. Moreover, it was not necessary; in Birmingham they had an organization that had the advantage of having the maternity work and the gynaecological work of the two Institutions co-ordinated. The sum needed to allow them to carry on was very small, compared with what would be the cost of building and maintaining a municipal hospital. A particular advantage in having the work of the two Institutions co-ordinated was that it offered good educational opportunities. The Medical Board had estimated that 25 per cent of the cases, approximately 1,105 cases, admitted to the hospital were 'due to mistake, neglect or ignorance'.<sup>79</sup> There was an urgent need to prevent those diseases which too often resulted in permanent ill-health. They had the necessary knowledge to save those poor women from ever having to go to Sparkhill and it was their duty to impart that knowledge to others. Further, they had unique facilities in the Institution for the training of midwives and medical students, as they covered the whole range of the diseases of women. Nettlefold was of

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<sup>78</sup> Ibid.

the opinion that by using this knowledge they could save women being admitted to hospital unnecessarily. It was also good business; preventative work was not only better and cheaper in the long run. Further, it was more satisfying to see 'something accomplished something done'.<sup>80</sup>

The key to achieving this was education and in this respect, Nettlefold considered that the Midwives Act had not been an unqualified success. The problem was the varying standard of midwives on the Midwives Roll, although he acknowledged that, with a national scheme of training, there were signs of progress in that direction.<sup>81</sup> Nettlefold thought that one institution in Birmingham that dealt with all the diseases of women could prove more helpful in taking things forward than could be achieved through two separate institutions. The Management Board considered that their educational role, although 'not yet as large as they hoped it would be', was perhaps the most important aspect of their work; its aim being to ensure that, 'in Birmingham and its immediate neighbourhood, mothers and babies should receive proper treatment from the very beginning'.<sup>82</sup> A training programme for midwives had been commenced and in 1911, 8 pupil midwives had passed their CMB. A further 13 pupils had started that same year.<sup>83</sup> Nevertheless, the Governors realized that there were still a large number of untrained midwives in the city and they would not see the real benefit of the improvements in midwifery training until the older midwives had died out. A further problem was that many pupil midwives failed to complete the period of study; various excuses

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<sup>79</sup> Ibid., HC/WH 1/10/6, Annual Report, 1913.

<sup>80</sup> Ibid., HC/WH 1/2/5, Management Committee, 12 December 1911.

<sup>81</sup> Ibid. Only 92 of the 105 registered midwives in Manchester in 1905 could produce evidence of formal training. The 'bona fides' included seven women who could neither read or write. Mottram, 'State Control in Local Context', p.141.

<sup>82</sup> BCA, BMHW, HC/WH 1/10/6, Annual Report, 1913.

were given but most found the work too hard or were not capable and dismissed. Perhaps to get an insight into the life of the trainees, the Chairman, Mrs Dora Walker spent the weekend working as a pupil midwife and reported that she was very pleased with the way the hospital worked.<sup>84</sup>

It is possible that some bona fide midwives found the training too intensive; Mr Jordan considered that the time of training should be increased, as he thought it was impossible to teach them adequately in the short space of four months.<sup>85</sup> Other institutions experienced similar problems and in 1916 the CMB increased the period of training to six months. Exceptions were made for where: three years nurse training had been undertaken in a general hospital with not less than 100 beds; a Poor Law institution, if recognized by the Local Government Board for nurse training; or if enrolled as a Queen's nurse by the Queen Victoria Jubilee Institute for Nurses.<sup>86</sup> Further encouragement was given to bona fide midwives in Birmingham when the Citizens Committee agreed to pay for their training.<sup>87</sup> By 1919, it would appear that some of these difficulties had been overcome; the reports of the Maternity Committee show that:

76 pupil midwives had been accepted for training during that year, 50 had taken their C.M.B examination, and 48 passed. The remaining 26 had not yet completed their training or taken their examination. Eight midwives had attended for lectures only. 21 medical students (11 men and 10 women) applied for training and were accepted.<sup>88</sup>

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<sup>83</sup> Ibid., HC/WH 1/2/5, Management Committee, 12 December 1911.

<sup>84</sup> Ibid., HC/MH 1/4/1, Maternity Hospital House Committee, 2 May 1916, 16 January 1917.

<sup>85</sup> Ibid., HC/WH 1/10/5, Annual Report, 1912.

<sup>86</sup> Ibid., HC/MH 1/4/1, Maternity Hospital House Committee, 18 July 1916.

<sup>87</sup> Ibid., 20 February 1917.

<sup>88</sup> Ibid., HC/WH 1/10/7, Annual Report, 1919.

Thereafter, the hospital achieved between 95 and 100 per cent pass rates in the CMB examinations. This helped to raise the profile of the hospital and also earned them respect within the profession. In 1921 Dr Robertson asked the hospital to accept pupil midwives, employed by the Corporation, to take their lectures at the Maternity Hospital. A similar request was made by Glamorgan County Council, who enquired if the Maternity Hospital would be able to train 20 midwives on their behalf.<sup>89</sup>

It is likely that such requests were welcomed; nationally there was a shortage of pupil midwives, a situation that was ongoing. A conference of Maternity Hospitals in 1924, called to discuss the matter, and the CMB proposals to extend the period of training in light of this, failed to resolve the matter. The Honorary Secretary, Mr Aston reported that neither the Ministry of Health, or the CMB were able to do anything about it; the only option for the Hospital was to accept pupils at a reduced fee.<sup>90</sup> This was not a viable proposition as in 1925 the training periods increased from three months to six months for a trained nurse and six months to twelve months for untrained staff. This resulted in an increase in fees to £40 and £55 respectively, although a concession was made for trained nurses who did not intend to practise as midwives, who were charged £30.<sup>91</sup> As other matrons reported, the shortage of pupils continued, largely on account of the fees. Payment for training was one of the major changes of the Midwives Act; midwives could no longer be paid for working on the wards and usually had to supply their own uniforms. As Mathers and Mackintosh have pointed out, 'This had restricted the numbers and type of women training as midwives since working-class

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<sup>89</sup> Ibid., HC/MH 1/4/2, Maternity Hospital House Committee, 7 June 1921, 17 July 1922.



women could not afford the fees or the uniform.<sup>92</sup> It is probable that the Committee got particular satisfaction from the request by the General Hospital, to undertake the training of their midwives and medical students.<sup>93</sup> Previously, there had been fierce rivalry between the two institutions, as the General Hospital had district midwives' houses in the same areas as the Maternity Hospital. They had been unable to reach a compromise agreement but the above request suggests a closer working relationship had developed between them.<sup>94</sup>

Midwifery training became increasingly important to the Institution as a useful source of income. Encouraged by the success of their pre-registration training programmes, it was suggested that postgraduate lectures be held. After some discussion with the Medical Board, Hilda Shufflebothan confirmed that a programme of lectures had been agreed. These would run for six months between October and March each year; they would be free of charge for in-house midwives. Shufflebothan was also able to report that the Medical Officer of Health was strongly in favour of this and the Council Homes would help in any way they could.<sup>95</sup> It is to the co-operation that existed between the municipal maternity service and the Maternity Hospital in Birmingham that Loudon attributes the low rate of maternal mortality in the city.<sup>96</sup> Nationally, there was considerable variation in MMRs and regional differences in the proportion of hospital deliveries. For example, in the 1930s Manchester had one of the highest proportions of institutional deliveries in Britain, with 43 per

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<sup>90</sup> Ibid., HC/MH 1/4/3, 6 May 1924, 20 May 1924.

<sup>91</sup> Ibid., 17 March 1925, 21 April 1925.

<sup>92</sup> Mathers and Mackintosh, *Born in Sheffield*, p.51.

<sup>93</sup> BCA, BMHW, HC/MH 1/4/2, Maternity Hospital House Committee, 1 November 1922.

<sup>94</sup> Ibid.

<sup>95</sup> Ibid., 4 July 1922, 11 July 1922.

cent of mothers delivered as in-patients and eight per cent delivered by the hospital's district service. A further 39 per cent of patients were delivered at home by midwives, of these 10 per cent were booked home deliveries by a doctor. In Birmingham, there were many more mothers delivered at home by midwives and fewer in-patient deliveries. The percentage of home deliveries by doctors was similar to that in Manchester. There was, however, a notable difference in the MMRs; 27.3 in Birmingham compared with 43 in Manchester.<sup>97</sup> As Loudon has noted, 'What was conspicuous in Birmingham... was an exceptionally well-integrated maternity service (and) a high standard of co-operation and integration between all concerned with maternal care'.<sup>98</sup>

Howsoever the maternity services were organized, the standard of training for midwives and medical students was a vital element in improving obstetric care. As noted above, education was a high priority at the Institution and the hospital continued to accept pupils for midwifery training on behalf of a number of municipal and voluntary Institutions, including the Royal United Hospital, Bath, who asked them to take fourth-year nurses from the Hospital for CMB training. There were also a number of requests for the hospital to accept midwives to gain experience on the District, including West Bromwich Guardian's midwives and pupils from Coventry and Warwickshire Hospital.<sup>99</sup> This indicates that by the mid-1920s, developments in the District midwifery service, such as ante-natal clinics and after-care initiatives (discussed below), were beginning to become more widely known. There had long been concern

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<sup>96</sup> Loudon, *Death in Childbirth*, p.227.

<sup>97</sup> Ibid.

<sup>98</sup> Ibid.

<sup>99</sup> BCA, BMHW, HC/MH 1/4/3, 21 July 1925, 26 October 1925, 15 June 1926.

about the number of premature and stillbirths and in 1917 the question had been raised as to whether there was any relationship between this and how long the mothers had been working in factories, but no link could be found.<sup>100</sup> Nevertheless, the hospital's Infant Health Committee continued to monitor this; in their annual report for 1920 it was shown that in the last four months of the year, of the 253 babies born there were 36 stillbirths (14.2 per cent) and 15 neonatal deaths (5.3 per cent).<sup>101</sup>

**Table 7**

**Analyses of admissions September 1920 - December 1920**

	<b>September</b>	<b>October</b>	<b>November</b>	<b>December</b>
Admitted	64	66	76	71
Births	60	60	64	69
Stillbirths	7	12	11	6
Twins	3	2	2	1
Mothers discharged	73	67	80	73
Babies discharged	54	53	47	54
Maternal deaths	0	0	1	2
Infant deaths	6	2	3	4

HC/MH 1/4/2, Maternity Hospital House Committee, 4 January, 1921.

A further study was undertaken in May 1921 which looked specifically at infant mortality related to premature birth. The cause of death in 20 cases was analyzed and the evidence suggested that, if complications had been detected prior to the mother's confinement, some infant deaths could be avoided.

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<sup>100</sup> Ibid., HC/MH 1/4/1, 17 July 1917. This issue is explored in G. Braydon, *Women Workers in the First World War*, (London and New York, 1981), Chapter 5.

**Table 8**  
**Baby deaths May 1921**

Baby 1	Premature	8 months	Transverse presentation	6 days
Baby 2			Prolapse of cord version	11 days
Baby 3	Premature	6 months	A.P.H	8 days
Baby 4			Marasmus eclampsia	12 days
Baby 5	Premature	7 months	Lateral placenta praevia	45 minutes
Baby 6	Premature	7 months		4 days
Baby 7	Premature	7.5 months	External version lateral placenta praevia	17 days
Baby 8	Premature	? 8 months	Albuminuria	10 days
Baby 9	Premature	8 months	Albuminuria	8 days
Baby 10	Premature		Breech prolapse of cord	11 days
Baby 11	Premature	8 months	Puerperal mania	17 days
Baby 12a	Premature	6 months	Acute hydramnios	20 minutes
Baby 12b	Premature	6 months	Acute hydramnios	4 hours
Baby 13	Premature 2 <sup>nd</sup> twin	7 months	Chronic hydramnios induction	5 days
Baby 14	Premature 2 <sup>nd</sup> twin	7 months	Albuminuria	9 weeks
Baby 15	Premature	7 months	Albuminuria	5 & half weeks
Baby 16	Premature	8.5 months	Central placenta praevia	3 hours
Baby 17	Premature	6.5 months	Inducted for Chorea	4 days
Baby 18	Premature	8 months	?Spiafic	13 days
Baby 19	Premature	6.75 months		3 days

<sup>101</sup> Ibid., HC/MH 1/4/2, 14 June 1921.



During the early twentieth century it was widely believed that deaths in the first month were generally due to inherited weakness, but by the 1920s there was a growing recognition that neonatal deaths had ante-natal causes that were closely linked to preventable deficiencies in the mother's health.<sup>102</sup> This put the emphasis of infant health, which had previously concentrated on the infectious diseases and preventing infantile diarrhoea, to be extended to the ante-natal period and maternal care. There had been growing interest in the idea of ante-natal care in the years following the publication (in 1901) of an article in the *British Medical Journal* by Dr John William Ballantyne.<sup>103</sup> Ballantyne's ideas anticipated many of the developments in obstetric practice that were to take place in the coming decades, but his conception of routine ante-natal care was limited to the suggestion that pregnant women needed a medical eye kept upon them, 'even if only to relieve them of some of the minor ailments of pregnancy... and to secure a regularly-sent sample of urine for analysis'.<sup>104</sup> Ballantyne's article led to the development of ante-natal services in Scotland but elsewhere others were also beginning to think along similar lines.<sup>105</sup> Before World War I the majority of infant welfare work was done by voluntary organizations, but after the outbreak of war the Local Government Board (LGB) urged local authorities to set up more infant welfare centres. The LGB also outlined a complete welfare scheme which included the ante-natal period and care of the child between one and five years, and allowed a 50 per

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<sup>102</sup> Lewis, *The Politics of Motherhood*, p.62.

<sup>103</sup> 'A Plea for a Pro-Maternity Hospital', *BMJ*, 6 April 1901. Cited Oakley, *The Captured Womb*, p.46.

<sup>104</sup> *Ibid.*

<sup>105</sup> This development did not occur in isolation, but was part of a national and international movement. See *ibid.*, pp. 49-54.

cent grant towards the expenses incurred.<sup>106</sup> The Maternal and Child Welfare Act (1918) required each local authority to set up a maternity and child welfare committee. It also enabled municipal authorities to fund maternity and child welfare work, which included 'salaried midwives, health visitors, antenatal clinics, day nurseries and free or cheap food for mother and child'.<sup>107</sup> Nonetheless, progress was slow and the provision of municipal ante-natal services in England was uneven. For example, in Sheffield one large central clinic was established which women from all over the city had to attend; by comparison, Nottingham, with half the population of Sheffield had 15 clinics.<sup>108</sup> In part, the difference may be explained by political pressure; in Huddersfield the Medical Officer of Health had the help of the town's Mayor, who lent his support for proposals for a comprehensive scheme that included the appointment of lady health visitors, a milk depot and a requirement to notify births.<sup>109</sup> Similarly, Marjorie Spring Rice has observed that Birmingham 'was notable for excellent clinics and home-help services'; they also took over the administration of the old Poor Law hospitals, such as Dudley Road.<sup>110</sup> In addition, the Corporation established many of the facilities provided for in the 1918 Act, including health visitors, ante-natal clinics and cheap food and milk for expectant mothers and infants.<sup>111</sup> In the early 1920s there was no provision for ante-natal care in the lying-in charity which was a matter of concern to the Infant Health Committee. They considered that maternal and

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<sup>106</sup> Ibid, p.56.

<sup>107</sup> Ibid., p.54.

<sup>108</sup> Mathers and Mackintosh, *Born in Sheffield*, p.71.

<sup>109</sup> H. Marland, 'A Pioneer in Infant Welfare: the Huddersfield Scheme, 1903-1920', *Social History of Medicine*, 5 (1993), pp.32-34. The voluntary scheme to notify births, instituted 1916, was particularly successful. By 1934, 77 per cent of births were registered which was some 27 per cent higher than elsewhere. See Oakley, *The Captured Womb*, p.55.

infant deaths could be reduced if this was introduced on the District. The Committee called a meeting of community midwives to assess how much ante-natal work they were currently able to do and what form it took. As required by the Central Midwives Board ruling in 1915 (that midwives should enquire into their patient's general condition in pregnancy), midwives were giving advice regarding general care of the mother's health, warned women of the dangers of headaches and swollen feet and advised them to notify the midwives if they noticed these. One midwife stated that in the case of women at work, she always enquired into the nature of work and, if at all unsuitable, she advised the woman to change her job. Further, if for any reason the midwife suspected that the home conditions were not good, she visited her at home and gave further advice. Nevertheless, the Committee were concerned that there was no clear evidence that midwives were getting the augmented milk and food supplies for mothers needing them. They were also particularly anxious that the patient should be seen during the last month of pregnancy, as this would allow the mothers to be measured and the position of the baby to be estimated. The midwives said this would be very difficult; mothers seemed to resent having to come up to the clinic and the same applied to being visited at home. Also, the midwives said that their workload was very heavy and they did not have time.<sup>112</sup>

Thus, there were two great obstacles in the way of ante-natal care, resentment of the mothers at what they considered undue interference and the heavy demand it would make on the time of midwives. According to the

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<sup>110</sup> M. Spring Rice, *Working-Class Wives. Their Health and Conditions* (2nd. 1981, London, 1939), p.viii.

<sup>111</sup> Ibid. See also Loudon, *Death in Childbirth*, p.227

<sup>112</sup> BCA, BMHW, HC/MH 1/4/3, 5 January, 1924.

midwives, mothers did not want to attend the hospital's out-patient clinics, even when advised to do so. They appeared to think that they would be made to come into hospital for the birth. If these were the views of Birmingham women they were not universally held. In Sheffield the ante-natal clinics were particularly successful in attracting women, many who had been encouraged by their friends to attend. Mathers and Macintosh have suggested that women were desperate for knowledge and advice, pointing out that some of them showed a shocking ignorance of childbirth. A first-time mother who attended the clinic admitted that she had no idea where the baby would come from.<sup>113</sup> As Jane Lewis has observed, much of the advice given to mothers in the ante-natal period was intended to protect the foetus. Similarly the term 'postnatal care' was synonymous with infant rather than maternal care.<sup>114</sup> Women's groups, such as the Women's Co-operative Guild, argued that the welfare of the mother should have equal consideration to that of the child. This appears to have been the view of the Governors; they considered a number of possibilities regarding ante-natal care, including establishing a School for Mothers, where they could give health lectures and mothers could be given general advice regarding babies' clothes etc. It was thought however, that those who would attend would prefer to go to one of the municipal schools nearer their home, so it was probably not necessary to establish one in connection with the hospital. After discussing the matter with the Medical Officer of Health, they decided to devise a printed sheet, giving advice about care of their general health and what was normal or abnormal

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<sup>113</sup> Mathers and Macintosh, *Born in Sheffield*, pp.70-71.

<sup>114</sup> Lewis, *The Politics of Motherhood*, p. 35.



during pregnancy. These could be handed to the mother when she booked with the midwife.<sup>115</sup>

As in Sheffield, the ante-natal clinics soon became popular with expectant mothers, as did the baby clinics which showed an increase in the number of attendances each year.<sup>116</sup> The after-care of mothers and infants continued to be overseen by the Infant Health Committee. As noted above, infant deaths due to premature births contributed to neonatal mortality, as did death from preventable causes such as diarrhoeal disease and digestive disorders. If there was any cause for concern, such as premature or underweight babies, members of the Committee continued to visit babies during their first year of life. Around 200 babies were on their books each year; 1,316 visits were made during 1918, during which five babies died, two from influenza, two from pneumonia and one from measles. The remainder were in good health.<sup>117</sup> This reflected national initiatives in maternal education, particularly with regard to infant feeding and care of the newborn child.<sup>118</sup> As noted above, feminist historians have been critical of this emphasis on domestic ideology but, as Lewis has acknowledged, many women welcomed advice on infant care and management.<sup>119</sup> Furthermore, it would appear that support was needed; the Matron reported that many women were admitted in a weak condition due to inadequate diet and a lot of babies were born underweight. The archival evidence indicates that the emphasis was on practical help. As will be shown below, patients unable to pay for convalescent care had their

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<sup>115</sup> BCA, BMHW, HC/MH 1/4/3, Maternity Hospital House Committee, 5 January, 1924.

<sup>116</sup> Ibid., HC/WH 1/10/8, Annual Report, 1927.

<sup>117</sup> Ibid., HC/WH 1/10/7, Annual Report, 1919.

<sup>118</sup> The Inter-Departmental Committee on Physical Deterioration proposed leaflets giving advice on the rearing of babies and supervision by lady visitors should be given to new mothers, p.89.

fees paid by the Maternity Hospital House Committee. For example, in 1929 the Welfare Officer arranged for the fees to be paid on behalf of seven women; in addition, fees or part fees were paid for children at Broad Street Cripples Hospital. Charitable aid was also given in the form of baby clothes, groceries and extra milk (around 1,250 cases of milk were given from the hospital each year). Where necessary, for example, perhaps for single mothers, referrals were made to other agencies, such as the Salvation Army and the Citizens' Aid Society; arrangements were also made for needy cases to have free dinners at welfare centres. Women could also be seen by the dental surgeon, appointed to the Women's and Maternity Hospitals in 1929. This was particularly important for new mothers, as the foetal demand for calcium causes dental caries during pregnancy<sup>120</sup>

Notwithstanding the emphasis on infant welfare, the Governors were also concerned about the health of the mother. Those admitted to hospital remained in a convalescent ward for a further twelve days after the birth. A further period of convalescence was often thought advisable as many of the women had other young children at home. It would seem that working-class organizations were of the same opinion. In March 1917 the Chairman, Mrs Walker reported that she had had a meeting with the Citizens Committee regarding a convalescent home for mothers after their confinement. Subsequently, it was agreed that there would be a joint committee to look into this, with representatives from the Citizens Committee, the Maternity Hospital and the Maternity Sub-committee of the Public Health Department. The Convalescent Home was intended for women after their confinement and

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<sup>119</sup> Lewis, *The Politics of Motherhood*, p.67.

pregnant women who needed a rest. It was planned to provide accommodation for around 25 women and a house had been offered to the Citizens Committee for £60 per annum. Although not ideal, the house was in a good area, had a good garden and adequate lavatory accommodation which, the Committee noted, was at that time unusual but necessary. The Citizens Committee would contribute four-fifths of the cost and the Maternity Hospital one-fifth; each would then have the right to admit women, in relation to their payments. The Citizens Committee contacted the hospital in May 1917 to confirm that the Convalescent Home, to be known 'Springfield Home of Rest for Nursing Mothers and their Babies', was going ahead. The Maternity Hospital replied saying they were looking forward to co-operating with the Citizens Committee on what was 'an experimental scheme in the town and probably in the country'.<sup>121</sup>

Aside from the benefits to the patients, the Home was soon proving to be a useful means of relieving the pressure on beds. The following year the Committee agreed to accept mothers who were eight days post delivery, for the remaining period of their admission, to allow urgent cases to be admitted. There was no charge for these women, but patients were usually charged £1 1s, with their first child or 15/- for second and subsequent births.<sup>122</sup> As with the convalescent homes for the gynaecological patients, many women were able to get assistance from the Contributory Fund. Where this was not available, no charge was made for mothers who could not afford it. In 1919, 53 women were admitted to the Springfield from the hospital and a further five from the District. In addition, eight mothers, unable to pay for themselves

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<sup>120</sup> BCA, BMHW, HC/WH 1/10/8, Annual Report, 1929.

were sent for periods of between two weeks to a month. One advantage of the Home was that young siblings were able to go with the mother; older children were often sent to Moseley Hall (a municipal institution for young children) for the period of the mother's convalescence.<sup>123</sup> Initiatives such as these inevitably put additional financial pressure on the hospital and to resolve these, it was decided to launch a special appeal. This would take the form of a request in the local press for women to give £25 to the Maternity Hospital, after which they would be made a Life Governor of the hospital. Professor Whitehouse suggested they should ask Mrs Stanley Baldwin to launch the appeal, as he knew that she had a special interest in maternity care.<sup>124</sup> It was subsequently announced that the appeal had been very successful. Mrs Stanley Baldwin, Neville Chamberlain and the Lord Mayor attended the launch at the Civic Hall and £5,500 was raised through the appeal for 'Life Governors'; in addition, a further £4,000 was donated.<sup>125</sup>

From the early 1920s the hospital also received a substantial amount of income from training and lecture fees. As noted above, postgraduate lectures were commenced in 1922; these had proved sufficiently popular for the House Committee to consider refresher courses for midwives.<sup>126</sup> The Medical Officer of Health was strongly in favour of this, which perhaps suggests that he was aware that certification did not necessarily guarantee good practice. As Mottram has shown, in the inter-war years there remained a number of independent midwives who were careless about hygiene and lacked even the

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<sup>121</sup> Ibid., HC/MH 1/4/1, 20 March 1917, 15 May 1917.

<sup>122</sup> Ibid., 17 December 1918.

<sup>123</sup> Ibid., HC/WH 1/10/7, Annual Report, 1919.

<sup>124</sup> Ibid., HC/MH 1/4/3, Maternity Hospital House Committee, 1 March 1927, 25 October 1927.

<sup>125</sup> Ibid., HC/WH 1/10/8, Annual Report, 1927.



basic equipment required to attend a delivery. One woman in Manchester had a 'small bag with a filthy, bloodstained lining'... the scissors bloodstained, the thermometer broken and she had no vaginal douche or catheter'.<sup>127</sup> Further, midwives commonly used the same syringe, which was neither sterilized nor disinfected between cases, to give enemas and to douche normal and septic cases and, in cases of emergency, ante- and postpartum haemorrhage.<sup>128</sup> To some independent midwives, the measures taken to prevent infection may have seemed excessive for whilst they complied with the regulations in theory, this was not put into practice. When the Medical Officer of Health inspected the midwives in Manchester she found some with well-equipped bags that were never taken to confinements.<sup>129</sup> Equally, it is probable that there were many midwives who welcomed the opportunity to attend a refresher course and learn of the developments in obstetric care that occurred in the early decades of the twentieth century. Of these, perhaps the most significant was the use of x-rays in the ante-natal period. Previously, the use of x-rays in this field was limited by the time of exposure required before a complete picture of the foetus could be obtained. Technical developments, together with more powerful sources of x-rays, reduced the time of exposure and gave a better-defined image. This made radiography a useful diagnostic aid in a number of ante-natal conditions, including: 'the presentation and position of the foetus; the diagnosis of multiple pregnancy; the investigation of

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<sup>126</sup> Ibid., HC/MH 1/4/3, 16 September 1924.

<sup>127</sup> *Manchester MOH Annual Report 1905*, p.247. Cited Mottram, 'Midwife Regulation in Manchester', p.141.

<sup>128</sup> Ibid.

<sup>129</sup> Ibid., p.145.

foetal bony abnormalities; the signs of foetal death *in utero* and the diagnosis of extra-uterine pregnancy'.<sup>130</sup>

Radiography could also assist in determining the age of the foetus and the condition of the maternal pelvis. These investigations were not undertaken routinely, as the position of the foetus can usually be determined by ordinary clinical methods and of the 2,686 new patients that attended the out-patients department in 1929, only 54 women had x-rays taken.<sup>131</sup> Nonetheless, routine examination can sometimes be misleading, particularly if the patient is fat or the abdominal muscles held rigidly, when it may be difficult to determine such conditions as breech presentation. Radiography was also helpful in that it was the most accurate method of confirming a suspected twin pregnancy or of demonstrating an unsuspected one; in addition, foetal abnormalities could usually be shown.<sup>132</sup> Ante-natal radiography was particularly useful in that the images it provided caused obstetricians to revise their views on a number of matters that had long been accepted. As Gilbert Strachan has pointed out, textbook illustrations were usually drawn from organs removed at autopsy, often fixed and shrunken which distorted their natural appearance. This had sometimes led obstetricians to inaccurate conclusions. For example, radiography confirmed (as Smellie had taught), that in the vast majority of cases, at the onset of labour the head engages in the transverse position, rather than the oblique.<sup>133</sup> As indicated above, only a small number of women at the hospital had x-rays, which may suggest that they were only used when some abnormality of pregnancy or labour was suspected. There

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<sup>130</sup> G.I. Strachan, 'Radiography in Obstetrics and Gynaecology', in Munro Kerr et al., *British Obstetrics and Gynaecology*, p.240.

<sup>131</sup> BCA, BMHW, HC/WH 1/10/8, Annual Report, 1929.

<sup>132</sup> Strachan, 'Radiography', pp.241-42.

were 959 such women admitted in 1929 but this did not necessarily mean that medical intervention was necessary; some of these were delivered soon after admission, some were kept under observation until labour started, whilst others were sent home and asked to return later when labour commenced.<sup>134</sup>

A further aid to diagnosis was the introduction of the Zondek and Aschheim test for pregnancy. Work on the sex hormones in the early 1920s had provided an entirely new basis for a test for pregnancy and in 1927 Zondek and Aschheim described experiments showing that implantations of pituitary tissue into immature female mice produced precocious sexual maturity. The injection of urine from pregnant women produced the same result and it was decided to investigate this further to establish if this could provide a satisfactory means of diagnosing pregnancy. Early morning urine was collected from 126 women known to be pregnant and injected into mice; 122 showed a positive reaction and of the remaining four, one miscarried three weeks later whilst the others proceeded to full term. This test was thought to be of particular value because it was positive in the early stages of pregnancy when clinical diagnosis was still difficult.<sup>135</sup> Thus, a number of scientific and technical developments were being introduced into obstetric care and to reflect this there was a greater emphasis on the theoretical content of midwifery training. To facilitate this, the training programme was organised into two blocks; the first six months were directed towards theory whilst the final six months were spent in clinical practice. It was also agreed that in

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<sup>133</sup> Ibid., p.242.

<sup>134</sup> BCA, BMHW, HC/WH. 1/10/8, Annual Report, 1929.

<sup>135</sup> H. Allen and F. Dickens, 'The Zondek and Aschheim Test for Pregnancy', *Lancet*, 4 January, 1930, pp.39-41. This article gives a detailed account of the research in this field. Pregnancy could be detected as early as nine days after the onset of the menstrual period was due.

future all lectures would be given by medical staff at the University, in conjunction with the Sister Tutor. It would appear that the current Sister Tutor was unwilling to take on this additional responsibility; she did not have a qualification in teaching and was also a sister in the out-patient department. At her request, she was relieved of her teaching role but continued in her post in the clinics. As her replacement, the University recommended a Sister Tutor who had recently gained a certificate in teaching and had an excellent reputation in this field.<sup>136</sup>

This reflected the higher status accorded by the University to midwifery education and the Maternity Hospital generally, as did the appointment of Hilda Shufflebotham to the Chair of Obstetrics and Gynaecology in 1926.<sup>137</sup> The Hospital continued to attract midwives for their postgraduate training programme, notably from municipal maternity services.<sup>138</sup> The archives suggest that there was particular interest in the district maternity service, in which the Lying-in Charity had invested extra resources. In 1928, Mrs John Feeney donated £1,500 for the purchase of a new District House and the following year they had appointed a District Surgeon. It was reported that this arrangement had been appreciated by the midwives, as it avoided patients being referred to hospital unnecessarily.<sup>139</sup> Nevertheless, there were risks attached to domiciliary midwifery, notably emergencies such as postpartum haemorrhage which was a very real danger. In 1935 Hilda Lloyd (nee Shufflebotham), established the Emergency Obstetric Service (Flying Squad), to deal with such emergencies, this being only the second such

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<sup>136</sup> BCA, BMHW, HC/MH, 1/4/3, Maternity Hospital House Committee, 21 May 1927.

<sup>137</sup> *Ibid.*, 16 March 1926. Shufflebotham was the first woman to hold such an appointment.

<sup>138</sup> *Ibid.*, 21 December 1926. Among others, the MOH in Sheffield asked if midwives from Smethwick could attend the postgraduate course.



service in the country. The purpose of the Flying Squad was to provide treatment for patients in their own homes if their condition was such that removal to hospital might have fatal consequences. The team consisted of an obstetrician, a midwife and a medical student together with the necessary equipment for dealing with the case, including oxygen and blood for transfusion. The Flying Squad was always taken by ambulance (one vehicle always being kept in readiness).<sup>140</sup> The Emergency Maternity Service proved to be of great value; 23 calls were made during 1939 and, in the majority of cases, the life of the patient was saved.<sup>141</sup>

Notwithstanding the acknowledged high standard of domiciliary care in Birmingham, there was an increase in the number of admissions to the Maternity Hospital each year. For example, in 1929 there were 1,711 admissions, being an increase of 63 of those admitted the previous year. Of these, 1,487 women were delivered in hospital, compared with 1,358 cases delivered on the District. In total, 1,698 women were discharged and 31 deaths, giving a maternal mortality of 1.8 per cent.<sup>142</sup> Despite the increase in accommodation afforded by the new hospital (opened in 1927), the shift to hospital deliveries put considerable pressure on beds. This resulted in the hospital having to transfer a number of cases, which had already been booked at the Maternity Hospital, to the municipal hospitals, Dudley Road and Selly Oak. The underlying problem was the shortage of maternity beds in the

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<sup>139</sup> Ibid., 17 January 1928, HC/WH 1/10/8, Annual Report, 1929.

<sup>140</sup> Archives of the Royal College of Obstetricians and Gynaecologists A 4/7/5, 'The Emergency Obstetric Service (Flying Squad)', *Quarterly Circular of the Red Cross Blood Transfusion Service*, 1951. Cited H.J. Stokes-Lampard, Professor Dame Hilda Lloyd-Rose, FRCOG, DBE, MBChB, Hon LLD, FRCS, Hon FRFPS, Hon MMSA 1891-1982. *Her Life and Her Influence On Others*, (MSc in Primary Care, University of Birmingham) nd.

<sup>141</sup> BCA, BMHW, HC/WH 1/10/10, Annual Report, 1939.

<sup>142</sup> Ibid., HC/WH 1/10/8, Annual Report, 1929.

city to cope with the increased demand by women for admission to hospital. This reflected the demand for hospital beds nationally, which had continued to rise during the 1920s and 1930s. Lewis has argued that this was consumer led; noting that by choosing to be delivered in hospital, mothers had 'a ten-day rest (which) made sense in the context of the hard household labour performed by working-class women'.<sup>143</sup> Thereby, the demand by women for hospital delivery can in part be explained by the circumstances of their lives. We learnt in the previous chapter of working-women's experience of married life and motherhood; poverty and poor housing made hospital a desirable alternative to home for many women. Within this context the call for hospital births came mainly from working-class organizations, such as the Women's Co-operative Guild who stressed that, with their lack of running water and absence of privacy, working-class homes were unsuitable for childbirth. They also pointed to the need for working-class women to go into hospital in order to secure adequate rest.<sup>144</sup> By 1918 the Guild were calling for 'a doctor to supervise every case and enough hospital beds to accommodate those living in poor home conditions'.<sup>145</sup>

The number of admissions continued to increase; in 1939, 1,554 women were admitted to the hospital, as compared with 1500 in 1938. The year had been busy in all departments, with 9,493 attendances at the ante-natal clinic, 815 at the post-natal clinic and 625 attendances at the baby clinic. The district midwives had delivered 899 women in their own home, with the

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<sup>143</sup> J. Lewis, 'Mothers and Maternity Policies in the Twentieth Century', in J. Garcia, R. Kilpatrick and M. Richards (eds), *The Politics of Maternity Care. Services for Childbearing Women in Twentieth-Century Britain* (Oxford, 1990), pp.15-16.

<sup>144</sup> *Ibid.*, p.20.

<sup>145</sup> Women's Co-operative Guild (1915 and 1917). Cited *ibid.*, p.19.

assistance of the District House Surgeon in any cases of difficulty.<sup>146</sup> Education continued to be a priority; 51 pupil midwives and 35 medical students had been accepted for training. In addition, a course of instruction for the Midwives-Teacher's Diploma had been held in conjunction with the University, attended by 35 candidates. A series of lectures and practical demonstrations in Gas Air Analgesia had also been given to trained midwives, which 12 candidates had attended, all of whom were awarded certificates.<sup>147</sup> As may be expected, the outbreak of war in September caused a number of problems. Plans for a new operating theatre had to be abandoned; instead they had to build air raid shelters to protect the present theatres. There was also a need to protect the wards and other departments and a number of auxiliary firemen were on duty at the hospital every night. Perhaps the most disappointing news was the postponement of the scheme to build a new Maternity Hospital at Edgbaston. Mrs Neville Chamberlain had made a Broadcast Appeal earlier in the year for the sum of £125,000 to complete this project. This had resulted in the sum of over £5,000 being received in donations and within a few weeks over £63,000 was subscribed. Since the outbreak of war, very few donations had been received and it was therefore decided to postpone the scheme until more favourable times.<sup>148</sup>

The purpose of this chapter has been to examine how the Charity developed maternity services in the early decades of the twentieth century and inter-war years. As noted in the introduction to this thesis, maternal health and infant welfare during this period has attracted a good deal of historical scholarship. Particular attention has been given to midwives, many

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<sup>146</sup> BCA, BMHW, HC/WH 1/10/10, Annual Report, 1939.

of whom were disenfranchised by the legislative requirements of the 1902 Midwives Act. As has been shown, the high maternal mortality in the early decades of the twentieth century was largely due to puerperal fever, inadvertently spread by the birth attendant. This is not to suggest that 'bona fide' midwives were solely to blame; general practitioners could also be the means by which this infection was spread. The key to resolving this lay in educating all those who attended women in labour and to this purpose the Maternity Hospital and Lying-in Charity made education a priority. Their approach to maternal health and infant welfare was in part influenced by national policies but the way they were implemented in Birmingham, notably in regard to cooperation between municipal and voluntary agencies, earned them the respect of their contemporaries. It also ensured the continuation of the gynaecological and maternity services of the Charity, and their teaching function, which continued in a new era of health care, through their incorporation into the United Birmingham Hospitals in 1948.

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<sup>147</sup> Ibid.

<sup>148</sup> Ibid.



## Conclusions

The purpose of this thesis has been not merely to give an account of the history of the Birmingham and Midland Hospitals for Women but to relate it to other aspects of social life, in particular, the motivation of those founding and supporting such institutions and the social circumstances of the working classes in Birmingham in the later decades of the nineteenth and first half of the twentieth centuries. As has been shown, industrialization caused a number of problems in Birmingham, particularly with regard to housing and sanitary conditions in the town. Notwithstanding the sweeping condemnation made by Robert Rawlinson in his report into the sanitary conditions in Birmingham in 1849, the same conditions existed in 1875. Essentially this was due to political squabbles and lack of investment by the Corporation. There is a consensus among historians that the catalyst for change in Birmingham was the Civic Gospel, as preached by the nonconformist minister George Dawson. Other nonconformist ministers were to take forward this gospel of public duty including Dr W. Dale, Minister of Carrs Lane Congregational Church, where many of the families associated with the Women's Hospital worshipped. Dale's message to his congregation to take a greater interest in civic affairs prompted a number of his parishioners to seek election to the Town Council, including Joseph Chamberlain. As we have seen, an energetic programme of works, designed to improve living conditions for the working classes was put into place. In addition, the nonconformist community established schools for the adult working classes and many of the city's hospitals. The same families were also responsible for the foundation of

those institutions that contributed to the civic renaissance of the town. Their shared political and religious philosophies underpinned their philanthropic efforts, thus precluding the squabbles and rivalry between institutions that Pickstone has reported in Manchester.<sup>1</sup> Indeed, the same names appear as subscribers on the list of a number of different charities, particularly in regard to the voluntary hospitals of the town.

Few would doubt that their religious beliefs underpinned their philanthropic activities. We have seen from family correspondence that a sense of public duty was instilled in childhood and influenced their actions throughout their adult life. In relation to the founding of the Birmingham and Midland Hospital for Women, this translated into addressing what was considered to be an unmet need, a hospital specifically for the diseases of women. A successful businessman, Arthur Chamberlain's appeal for the foundation of the hospital succeeded where early attempts had failed, largely due to his well researched evidence of need and cogent arguments for the benefits that would be accrued from its foundation. This sound, businesslike approach is evident in all aspects of the governance of the Institution; management costs were kept to a minimum whilst no money was spared if human suffering could be alleviated or life could be saved. It is this practical benevolence that characterized nonconformist philanthropy; aware that money alone could not improve the lives of the working classes, they put their efforts into addressing social problems such as housing conditions or reducing maternal mortality by improving the education of midwives and medical staff. The promotion of women in the Institution also reflected the nonconformist progressive views

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<sup>1</sup> J.V. Pickstone, *Medicine and Industrial Society. A History of Hospital Development in Manchester and its Region 1752-1946* (Manchester, 1985), Chapter Four.

towards womanhood. The Unitarian tradition of more advanced education for women made them eminently suitable for the intellectual demands of the management role, a decision seen by Arthur Chamberlain to be a major element in the success of the Institution. This is contrary to the view of Keir Waddington, who has suggested that women's contribution to charitable work was generally restricted to the never-ending task of fund-raising, visiting patients and aftercare. As such, Waddington has argued that they were excluded from hospital administration which was considered close enough to business to be seen exclusively as a male sphere.<sup>2</sup> The Birmingham case can be seen to challenge previous assumptions and the evidence presented in this thesis shows that women took an active role in all aspects of the hospital. There can be no better example of the extent of their contribution than Alice Beale, who was a Governor of the Institution for over 60 years, serving on the Management Committees of both the Women's Hospital and Maternity Hospital. Beale was also largely responsible for the provision of convalescent care and the opening of the Maternity Hospital, in which she maintained her interest throughout the inter-war years.

Unlike the Chelsea Hospital for Women, this was not a 'moral institution'; there was no attempt by the Governors to impose their religious convictions on others. Notwithstanding their deeply held beliefs, religion did not play a significant role in the day-to-day life of the hospital. In contrast to the Ladies' Committees described by Ornella Moscucci, the people charged by the Management Committee to visit the wards and departments undertook a far

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<sup>2</sup> K. Waddington, *Charity and the London Hospitals 1850-1898* (London and New York, 2000), p.148.

more useful role than attempting to reform 'fallen' women.<sup>3</sup> The primary aim of the visit was to speak to the women and to learn of their concerns; as a result of their visits, important developments such as convalescent homes were established and provision made for the care of the dying.

The employment of professional women was as successful as the promotion of women in management; the recruitment of the first female dispenser was indicative of their progressive views on professional careers for women. Their appointment of the first female House Surgeon can only be adequately described as pioneering. We have seen the strength of opposition to the employment of women doctors and their restrictions for a number of years largely to employment in hospitals run by women, in part, as a means to promote their careers. The Women's Hospital was one exception to this, as was the Children's Hospital in Birmingham which soon followed in its stead. As we have seen, a number of women doctors, such as Annie Clark and Mary Sturge chose to stay with the hospital throughout much of their professional career. This would suggest that they supported the clinical practice of their colleagues and the ethos of the hospital. This contradicts the argument of some scholars of the period who have proposed that the medical practice of women doctors was fundamentally different to that of men. Furthermore, these women were active in the women's medical movement. Sturge and Clarke were members of the Medical Women's Federation, as was Professor Dame Hilda Lloyd. We have noted that Hilda Lloyd (*nee* Shufflebothan) was appointed consultant at the Women's and Maternity Hospitals and assistant Professor of Obstetrics and Gynaecology at the University of Birmingham.

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<sup>3</sup> O. Moscucci, *The Science of Women. Gynaecology and Gender in England 1800-1929* (Cambridge, 1990, paperback edition, 1993).



She subsequently took the Chair of Obstetrics and Gynaecology in 1943, following the death of Professor Sir Beckworth Whitehouse.<sup>4</sup> The first female to achieve a Professorship, she was warmly congratulated by her colleagues, particularly those within the Women's Medical Federation. The President wrote:

Your splendid appointment must fill us all with hope as well as with pride, and we can really look forward to the day when professional achievement alone shall be the criterion, irrespective of sex. Medical women not only congratulate you, they thank you for all the splendid work you have, from the beginning, put into your professional life.<sup>5</sup>

Professor Lloyd was to raise the profile of women in medicine still further when she was appointed President of the Royal College of Obstetricians and Gynaecologists in 1949. The first female president of any Medical Royal College, she served a three-year term of office. In the Birthday Honours list June 1951 Professor Hilda Lloyd-Rose was knighted Dame of the British Empire, 'for her services to her Speciality, College and her University'.<sup>6</sup>

A second theme in this thesis has been the rise of surgical gynaecology in the latter decades of the nineteenth century. Despite the controversial nature of procedures such as ovariectomy, the innovative techniques pioneered by Tait and others were ultimately to extend the boundaries of general surgery. It is noticeable in the tributes paid at the time of his death, that Tait was more highly regarded in America than Britain. In part, this may be because

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<sup>4</sup> *Birmingham Post*, 10 July 1944.

<sup>5</sup> Wellcome Library Medical Archive, SA/MWF/3.133 iv (2), Special Collections, Medical Women's Federation, Biographies of Dame Hilda Lloyd.

<sup>6</sup> Obituary, 'Dame Hilda Rose', *British Medical Journal*, 7 August, 1982. Bertram Lloyd died in 1948 after a long period of illness. In 1949 she married Baron Theodor Rose, with whom she had graduated in 1916. She died shortly before her 91st birthday on 18 July 1982.

innovative techniques were more acceptable in America but it is likely that class and professional boundaries precluded his acceptance by the medical elite in Britain. Tait had to be forceful and determined to achieve his objectives and the innovative environment of late Victorian Birmingham was entirely suited to his cause. A more important question is the matter of exploitation; then as now, there is an imbalance in the doctor-patient relationship where the woman may allow the decisions regarding her care to be taken by the, usually male, medical practitioner. The picture of a medical man portraying himself as a powerful authority figure, an image some historians have projected, is difficult to reconcile with either the women we have considered in this thesis or the ethos of the hospital.<sup>7</sup> We have seen that the Governors monitored the medical care of patients and intervened if they considered it necessary to do so. Furthermore, whilst many women in the medical movement were deeply opposed to such radical surgery as ovariectomy, Mary Dixon Jones, one of the leading surgeons in America, was one of Tait's staunchest supporters. Like Tait, Dixon Jones embraced the use of pathological investigation and used microscopic data to inform her diagnosis. Older practitioners like Spencer Wells mistrusted the emphasis on the new laboratory sciences and did not use it in their clinical practice. The battle between the older and younger generation was most publicly played out in the Imlach Affair. It is not within our remit to judge the effectiveness of medical intervention but we are in a position to consider the outcome of an equally controversial procedure, Wertheim's hysterectomy. Condemned by many within the profession when first introduced, the operation has ultimately

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<sup>7</sup> J. Eliot Sewell, 'Bountiful Bodies: Spencer Wells, Lawson Tait, and the Birth of British Gynaecology', PhD thesis, John Hopkins University, 1990, p.330.

proved to be successful in prolonging life and continues to be used in the twenty-first century.

The medicalization of childbirth has been widely condemned by feminist historians but medical developments should be viewed within the context of the circumstances in which they arose. There was evidence of a higher maternal mortality in Britain than in many European countries, which suggested the need of education for all concerned. The Maternity Hospital and Lying-in Charity directed their efforts towards tackling maternal mortality through the isolation of patients with infectious disease and the education of medical staff and midwives. Furthermore, notwithstanding the national interest in matters of infant welfare, most initiatives in this area were largely the result of the local effort, either through the Maternity Hospital or the Health Department of the local government and the Medical Officer of Health. As we have seen, the cooperation between voluntary and municipal agencies has been seen as a contributing factor in the comprehensive provision of welfare services for mother and child. An issue that has received particular attention from historians is the provision of ante-natal care. This has been portrayed by some scholars as a strategy for the social control of women.<sup>8</sup> As has been shown, the introduction of ante-natal care at Birmingham Maternity Hospital was initially suggested by women governors, in an effort to reduce the number of avoidable infant deaths. Furthermore, there is no evidence to support the assumption that the trend towards greater intervention was not welcomed by women. The ante-natal care and infant welfare clinics at the Birmingham Maternity Hospital were well supported by mothers and, although home

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<sup>8</sup> A. Oakley, *The Captured Womb. A History of the Medical Care of Pregnant Women* (Oxford and New York, 1984), p.250.



delivery was promoted by the Lying-in Charity, there was an increasing demand for admission to hospital. The evidence presented in this thesis supports the findings of Tania McIntosh, in her study of motherhood in Sheffield between 1879-1939.<sup>9</sup> In Sheffield, as elsewhere, the demand for beds outstripped the supply. This reflected the national trend and was supported by working-class women's organizations who demanded sufficient hospital beds for all those who required them. To fully understand this it is vital that the circumstances of the period are taken into account. As Jane Lewis has observed, it was far easier to cope with a home birth in the later decades of the twentieth century than it was in the inter-war years.<sup>10</sup> Thus, as E.H. Carr observed, you cannot write about the past in the context of contemporary concerns and perspectives.<sup>11</sup> As has been argued in this thesis, working-class women had different priorities to feminists of today; they had their own sources of discontent but these were less a result of their sex than their class.

In conclusion, as with any area of historical study, judgements concerning causation or motivation are often the product of the historian's interpretation, and are impossible to prove.<sup>12</sup> The evidence presented in this thesis suggests that the nonconformist beliefs of the Governors underpinned their motives for the foundation of the hospital and influenced the way the Institution developed. It would, however, be misleading to suggest that these

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<sup>9</sup> T. McIntosh, 'A Price Must Be Paid for Motherhood: The Experience of Maternity in Sheffield, 1879-1939', PhD thesis, University of Sheffield, 1997.

<sup>10</sup> J. Lewis, 'Mothers and Maternity Policies in the Twentieth Century', in J. Garcia, R. Kilpatrick and M. Richards (eds), *The Politics of Maternity Care. Services for Childbearing Women in Twentieth-Century Britain* (Oxford, 1990), pp.15-16.

<sup>11</sup> E.H. Carr, *What Is History*. Cited, A. Green and K. Troup, *The Houses of History. A Critical Reader in Twentieth-Century History and Theory* (Manchester, 1999), p.7.

<sup>12</sup> *Ibid.*, p.6.



motives can be ascribed to all those who gave their support. Whilst acknowledging the benefits of their voluntary efforts, for many middle-class women charitable work was a way of breaking out of the domestic routine which might also be useful in opening doors closed to them in other spheres. It was also a reflection of the public spirit which found expression in the number of voluntary societies and charities which appeared in ever increasing numbers in the nineteenth century.<sup>13</sup> The motives of medical men are less easy to define; as with most people in professional careers, ambition to reach the top of one's profession undoubtedly played some part. This does not necessarily mean that they were self-serving or willing to compromise patient care. Certainly their appointments were not, as Lindsay Granshaw has proposed, seen as a 'stepping-stone' in their career; members of the honorary medical staff stayed at the hospital until they retired from their professional career.<sup>14</sup> There was of course some benefit to their private practice from this; firstly in raising their profile within the profession and with potential patients, plus the facilities to develop their surgical techniques. As made clear by Arthur Chamberlain in 1871, both these objectives were seen as legitimate aims for the hospital. The contribution made in the field of general surgery is one example of how such developments were adopted internationally.

A final reflection is that Birmingham and Midland Hospitals for Women Incorporated truly offered holistic care for women 'from the cradle to the grave'. One definition of philanthropy or charity is 'love of one's fellow man, and an inclination or action that promotes the well-being of others'.<sup>15</sup> It has

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<sup>13</sup> F. Prochaska, *Schools of Citizenship. Charity and Civic Virtue* (London, 2002), pp. 11-12.

<sup>14</sup> L. Granshaw, 'The Rise of the Modern Hospital in Britain', in A. Wear (ed.), *Medicine in Society. Historical Essays* (Cambridge, 1992), p.207.

<sup>15</sup> Prochaska, *Schools of Citizenship*, p.17.

been argued that a similar inclination guided the motives of all involved in the Birmingham and Midland Hospital for Women and its associated Institutions.

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